PART II

POLICIES AND PROCEDURES FOR HOME HEALTH SERVICES

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION OF MEDICAL ASSISTANCE

Revised: July 1, 2003

PART II - POLICIES AND PROCEDURES FOR HOME HEALTH SERVICES

CONTENTS

	APPENDIX A	Medical Assistance Eligibility Certification
	APPENDIX B	Definitions
Rev. 4/03		
Rev.	APPENDIX C	Home Health Cost Data Form (Freestanding)
Rev. 4/03		
Rev. 7/99	APPENDIX D	Home Health Cost Data Form (Hospital-Based)
Rev. 4/03	APPENDIX E	Georgia Better Health Care (GBHC) Revised
Rev. 4/03	APPENDIX F	Co-Payment
Rev. 4/03	APPENDIX G	Notice of Your Right to a Hearing
Rev. 4/03	APPENDIX H	Statement of Participation
Rev. 4/03		
Rev.	APPENDIX I	Health Insurance Claim Form (HCFA 1500) and Instructions
	APPENDIX J	Billing Manual

PART II CHAPTER 600

CONDITIONS OF PARTICIPATION

601. General Criteria

In addition to the general conditions of participation identified in Part I, Section 106 of this manual, providers in the Home Health Services Program must meet the following conditions:

601.1 Licensure and Certification

A. The home health agency must be currently licensed by the Standards and Licensure Unit of the Department of Human Resources.

B. The home health agency must be currently certified to render services under Medicare (Title XVIII).

Copies of the following documents must be submitted with the enrollment application:

1. The Medicare certification notice, indicating the counties for which the agency has certification, with the Medicare provider number; and

2. A copy of the License issued by the DHR Standards and Licensure office indicating services approved and the counties in which the agency is licensed to operate.

Rev. 1/01

3. A copy of the completed Office of Regulatory Services (ORS) ownership disclosure form or a copy of the Division's ownership disclosure form.

C. Home health agencies established after June 30, 1979 must be approved by and possess a Certificate of Need from the State Health Planning Agency. A copy of such certification must be submitted with the enrollment application.

Home health agencies established prior to July 1, 1979 must present certification of start-up date.

D. The information requested above should be submitted in one packet along with a completed DMA Statement of Participation to:

Rev. 4/03

Georgia Health Partnership - CIC
Provider Enrollment Unit
P. O. Box 88030
Atlanta, GA 30356

601.2 The home health agency must maintain current clinical records on all patients as described in Section 904.

601.3 The home health agency must maintain justification for home health services in the Plan of Care with a copy of the signed physician orders.

601.4 The home health agency must agree to periodic, on-site patient care reviews and financial audits by authorized representatives of the Division.

601.5 The home health agency must not bill the Division more than the rate charged private pay patients for similar services. The agency must maintain and make available records of both Medicaid and private pay patients for a minimum of three years in order to document compliance with this provision.

601.6 The home health agency must bill only for <u>completed</u> services rendered in the patient's home. If the agency attempts to visit a patient and the patient is not at home, the agency must not bill the Division for an attempted visit. Efforts made by home health agencies to bill the Division for service visits to patients not at home will not be reimbursed, or reimbursement made will be recouped.

Rev. 1/01

601.7 The home health agency is responsible for assuring that there is no duplication of services (see note box.) Additionally, the home health agency agrees not to provide services to members when those services are provided through other Medicaid programs. Other Medicaid programs include but are not limited to Children's Intervention Services, Children's Intervention School Services, Model Waiver Services, Mental Retardation Waiver Program, physician services, Perinatal Case Management, Pregnancy Related Services, Mental Health Services, Independent Care Waiver Program and Therapy Services.

Rev. 7/99

Note: When a referral is received for home health services, it is the responsibility of the home health agency to verify a member's participation in the Community Care Services program before providing services by contacting the local Area Agency on Aging.

Rev. 7/99 1/00

601.8 The home health agency must notify Provider Enrollment at the fiscal agent and the Division in writing of changes in enrollment status such as: name change, new address and telephone number, additional subunits or branches, dissolution of a corporation, voluntary termination from the program, loss of certification or licensure, or filing of bankruptcy petitions. Each notice of change must include the date on which the change is to be effective.

Rev. 1/01

601.9 Home health agencies that provide services under subcontract must submit copies of such contractual agreements to the Division. Such agreements must specify which home health services are being subcontracted and must specify that the Medicaid enrolled home health agency retains administrative and supervisory responsibility for staff and services subcontracted.

601.10 The need for home health services to be provided by a home health agency (HHA) that is not a governmental entity may not be certified or recertified, and a plan of care may not be established and reviewed, by any physician who has a significant ownership interest in or a significant financial or contractual relationship with the agency. "Significant financial or contractual relationship" means receiving any compensation as an officer or director of the HHA or a relationship that involves direct or indirect business transactions that, in any fiscal year, amount to more than $25,000 or five percent of the agency's total operating expenses, whichever is less. "Business transactions" means salaried employment contracts, agreements, purchase orders, or leases to obtain services, supplies, equipment and space. A physician will be considered to have "significant ownership interest" if he or she has a direct or indirect ownership interest of five percent or more in the capital, the stock, or the profits of the home health agency; has an ownership interest of five percent or more in any mortgage, deed or trust, note, or other obligation that is secured by the agency, if that interest equals five percent or more of an HHA organized as a corporation, or is a partner in an HHA organized as a partnership.

Rev. 1/01

601.11 The home health agency must disclose ownership information pursuant to Section106.25 of the Part I Policies and Procedures manual to the Division upon initial enrollment and annually thereafter. The agency may provide a copy of the Office of Regulatory Services disclosure form or a copy of the completed Division's Ownership Disclosure Form. These documents must be submitted to the Provider Enrollment Unit at the Division at the following address:

Division of Community Health
Division of Medical Assistance
Provider Enrollment Unit
2 Peachtree Street, NW
40th Floor
Atlanta, GA 30303-3159

601.12 Parent agencies, subunits, and branch offices must meet the guidelines outlined in the Rules and Regulations for Home Health Agencies Chapter 290-5-38-.06 from the Department of Human Resources, as described below:

A. A "Parent Home Health Agency" means the agency that develops and maintains administrative controls of subunits and branch offices.

B. A "subunit" means a semiautonomous organization that serves patients in a geographic area different from that of the parent agency. The subunit, by virtue of the distance between it and the parent agency is judged incapable of sharing administration, supervision and services on a daily basis with the parent agency and must, therefore, independently meet the licensing requirements for a Home Health Agency and shall be separately licensed. A subunit shall be separately enrolled as a provider in the Georgia Medical Assistance program and shall be assigned a unique provider number.

C. A "Branch Office" means a location or site identified in the application or endorsement thereto from which a home health agency provides services within a portion of the total geographic area served by the parent agency. (The total geographic area served by the parent agency is defined by the counties in which the parent agency is licensed to provide approved services as indicated by its license.) The branch office is part of the home health agency and is located sufficiently close to share administration, supervision and services on a daily basis in a manner that renders it unnecessary for the branch independently to meet these rules and regulations.

Rev. 1/01

601.13 The home health agency must submit to the Division two copies of its as-filed Medicare Cost Report and Medicaid Cost Data Form. In addition, each agency with a home office must submit two copies of its as-filed Medicare Home Office Cost Report and the Medicaid Home Office Cost Data Form. These documents must be submitted in accordance with the guidelines set forth in Section 1001.1.

Rev. 1/01

601.14 The home health agency must have established policies on informing patients of the Patient Bill of Rights and Advanced Directives. The home health agency must provide information on the Patient's Bill of Rights and Advanced Directives to all patients receiving services in the Home Health Services Program. An agency's patient records must contain documentation that such information was provided.

Rev. 1/01

601.15 The home health agency must not deny services to any eligible Medicaid member because of the member's inability to pay the copayment amount imposed. (See Appendix J.)

602. Community Care Services Program

Rev. 4/00
Rev. 4/03

Home health services provided to Community Care Services Program (CCSP) members must be provided by CCSP approved home health agencies currently enrolled in CCSP. The first 75 visits for CCSP members are reimbursed under the Home Health Program. These visits must be authorized on the Service Authorization Form (SAF) by the CCSP Care Coordinator. CCSP members must meet the eligibility criteria outlined in Chapter 700 to receive home health visits.

Rev. 4/03

CCSP members who require more than 75 visits receive the additional visits reimbursed under CCSP. These visits must also be authorized on the SAF by the CCSP Care Coordinator. A home health agency may not render home health services to a member under both categories of service at the same time. **To research a member's enrollment in waiver programs, contact GHP Inquiry Unit at 404-298-1228 or 1-800-766-4456.** Instructions for referral of patients between home health and community care services are contained in Section 804.

Rev. 4/03
Rev. 1/99

603. Independent Care Waiver Program and Traumatic Brain Injury Program

Rev. 1/00

Home health services provided to Independent Care Waiver Program (ICWP) members are reimbursed under the Home Health Program for the first 75 visits. ICWP members must meet the eligibility criteria outlined in Chapter 700 to receive home health services. The Georgia Medical Care Foundation (GMCF) and case manager determine the need for home health services and incorporate these visits into the Plan of Care (POC) and update the Participant Assessment Form (PAF).

Rev. 4/03

ICWP members who need more than 75 visits receive the additional visits reimbursed under ICWP. These visits are also incorporated into the POC and PAF by GMCF and the case manager. A home health agency may not render home health services to a member under both categories of service at the same time. **To research a member's enrollment in waiver programs, contact GHP Inquiry Unit at 404-298-1228 or 1-800-766-4456.** Instructions for referral of patients between home health and ICWP/TBI are contained in Section 806.

Rev. 1/99

NOTE: A member may **NOT** participate in more than one Medicaid waiver program at the same time. To research a member's enrollment in waiver programs, contact GHP Inquiry Unit at 404-298-1228 or 1-800-766-4456.

Medicaid Waiver Programs include:	**Category of Service (COS)**
♦ CCSP	590
♦ Independent Care	660
♦ Model Waiver	770
♦ SOURCE Demonstration Project	930
♦ Shepherd Care Project	660

CCSP members and other waiver members are not eligible to enroll in a Medicaid HMO.

Rev. 4/00

604. PeachCare for Kids

A home health agency can provide home health services to children enrolled in PeachCare for Kids. The home health agency must follow the policies and procedures outlined in the Home health Services Manual.

PART II - CHAPTER 700

SPECIAL ELIGIBILITY CONDITIONS

701. Special Member Eligibility Criteria

Rev. 1/01

The Medicaid Home Health Program is based on the philosophy of family and patient participation in providing patient care. Families and patients are expected to be taught care which can be rendered reasonably and safely by non-medical persons.

701.1 Acceptance of Patients for Medicaid Coverage

A. Patient admittance to home health services shall be based on:

1. An expectation that the care and services are medically reasonable and necessary for the treatment of an illness or injury, and the services can be met adequately by the agency in the patient's place of residence;

Rev. 1/01

♦ Home Health skilled and home health aide services are medically necessary and appropriate when the patient's medical records accurately justify a medical reason that the services should be provided in the patient's home instead of a physician's office, clinic, or other out-patient setting, according to one or more of the following guidelines:

a. Because of the patient's illness, injury, or disability, going to a physician's office, clinic, or other out-patient setting for the needed service would create a medical hardship for the patient. Any statement on the plan of care regarding such medical hardship must be supported by the totality of the patient's medical records.

Examples of medical hardship include:

- A patient who requires ambulance transportation,
- A patient in severe pain,
- A patient with bilateral upper extremity loss who is unable to open doors, use handrails or perform other activities, and needs help to leave his residence,
- A patient for whom leaving the home is likely to cause an exacerbation of his condition, and

- A patient who experiences shortness of breath that significantly hinders travel,

- A diabetic patient is wheelchair bound due to bilateral BK amputations and makes only infrequent trips from his residence because of medical complications.

Some examples of conditions that in themselves are not considered creating a medical hardship include the need to use portable oxygen, walking with a limp, or the need to use an assistive device such as a cane, walker or wheelchair. A wheelchair-bound patient who regularly drives a specially equipped vehicle to travel outside of the home is not considered to have a medical hardship. The need for routine transportation is not considered a medical hardship--assistance with transportation to medical appointments is available through the county departments of social services. The common need for a child to be supervised by an adult when outside the home also does not in itself justify providing care in the home.

b. Going to a physician's office, clinic, or other outpatient setting for the needed service is contraindicated by the patient's documented medical condition. The patient's condition is so fragile or unstable that the physician states that leaving the home is undesirable or detrimental under the circumstances.

Examples include:

- A newborn infant up to six weeks of age who has acute care needs or who is at medical risk,
- A patient just had surgery and has resultant weakness and pain. Because of her condition, her physician restricts certain activities and allows getting out of bed for only a short period of time,
- A patient with severe arteriosclerotic heart disease must avoid all stress and physical activity,
- A patient with a medical condition that requires protection from exposure to infections, and
- A patient who is just out of the hospital after major surgery.

c. Going to a physician's office, clinic, or other outpatient setting for needed service would interfere with the effectiveness of the service.

Rev. 1/01

Examples include:

- A young child who would not benefit from out-patient therapy because of extreme fear of the hospital where the out-patient setting is located;
- A patient living in an area where travel to out-patient therapy would require an hour or more travel;
- A patient who needs a service repeated at frequencies that would be difficult to accommodate in the physician's office, clinic, or other out-patient setting, such as daily IV infusions or daily insulin injections;
- A patient who needs regular and p.m. catheter changes and having Home Health in place will prevent emergency room visits for unscheduled catheter changes due to dislodgment or blockage;
- A patient who, because of the patient's illness, injury or disability, including mental disorders, has demonstrated past failure to comply with going to a physician's office, clinic, or other out-patient setting for the needed service, and has suffered or has a high probability of suffering adverse health consequences as a result, including use of emergency room and hospital admissions.
- A patient who is newly diagnosed with end stage renal disease has been prescribed a specialized diet with severe restrictions. Due to the patient's limited ability to understand from standard diet teaching only, it is necessary for the nurse to teach in the home to use examples of foods available to the patient. It will also be necessary to teach and train the caregivers in the home who will prepare the food. Attempting the teaching outside of the home setting would interfere with the effectiveness of teaching this patient and caregivers.
- A patient has an abdominal wound dehiscence. The wound care is extensive and requires irrigation and packing twice a day. The care will be accomplished by the patient's caregivers. The caregivers need to observe the nurse performing

the dressing changes more than once for teaching and they need to be observed by the nurse for assessment of understanding. They also need to learn sterile technique and how to prepare a sterile field in the home environment. Due to the extensive teaching needed, along with observation, teaching is most effectively accomplished in the home.

Rev. 1/01

- A patient who requires use of assistive devices specifically customized for the patient's home environment (bath chairs, shower grab bars) requires training on the use of those devices in the home for the training to be effective.

2. a referral from the patient's primary care physician (PCP) for members residing in an area covered by the Georgia Better Health Care program;

Rev. 1/99

3. a written Plan of Care established and periodically reviewed by the attending physician;

Rev. 1/99

4. continued supervision of the patient by the attending physician at least every sixty-two (62) days or every two (2) months;

Rev. 7/99

5. absence or inability of significant others to provide the services;

This does not mean, for example:

- ♦ Caregiver works;

Rev. 1/01

- ♦ Caregiver and/or patient is noncompliant with the treatment regimen, keeping medical appointments and/or assisting with medication compliance and med-pack setups;

- ♦ Caregiver uncomfortable or unwilling to provide care; or

Rev. 1/01

- ♦ Lack of transportation to a treatment facility, physician's office or other outpatient facility.

6. ineligibility for Medicare home health coverage.

B. Patients shall not be denied service based on their age, sex, race, religion or national origin.

Rev. 4/03

C. The home health agency must maintain the signed and dated physician orders (Plan of Care) for all services to be rendered to each Medicaid patient and for which the provider proposes to seek Medicaid reimbursement. If the physician fails to date his or her signature, the home health agency must indicate the date they received the plan of care.

Rev. 1/01

702. Place of Residence

Rev. 1/99

A patient's place of residence for home health services is the patient's home. "Home" means a house, apartment, condominium, trailer or other non-institutional structure used primarily for shelter. It does not include a hospital, daycare facility, skilled nursing facility, nursing facility, school, corrections facility, training center, or an intermediate care facility for the mentally retarded. Services provided in settings other than the home are not considered home health services and are not reimbursable under the Home Health program. Services must be provided in the member's place of residence.

PART II - CHAPTER 800

PRIOR APPROVAL

Rev. 4/03

801. General

Home Health services do not require prior approval. Prior approval will continue to be required for individual under twenty-one (21) years of age once the provider has complied with the requirements of Section 803.

Rev. 4/03

802. Medicaid/Medicaid Eligibles

Refer to Chapter 900 regarding coverage of services for individuals discharged from Medicare and admitted to Medicaid.

Rev. 4/03

803. Maximum Visits

The Division will only reimburse for a maximum of seventy-five (75) visits per member per calendar year for individuals who are twenty-one (21) years of age and older. For individuals who are under twenty-one (21) years of age, home health services exceeding seventy-five (75) visits per calendar year may be covered when such services are requested by a physician and determined to be medically necessary at the discretion of the Division. The request for services exceeding seventy-five (75) visits per calendar year must be received by the Division fifteen (15) business days before the visits are exhausted. The physician must document medical necessity in a letter of request written to the Division. The home health agency must document in a letter of consideration to the Division the number of visits exceeding seventy-five (75) that are medically necessary for the remainder of the year. Both requests should be submitted to the following address:

Rev. 1/00

Department of Community Health
Division of Medical Assistance
Post Office Box 38440
Atlanta, Georgia 30334
Attn: Home Health Program Specialist

The Division will notify the provider of its decision and the procedure to be used when billing.

Rev. 4/03

804. Community Care Services Program (CCSP) Referrals

Rev. 4/00

A. Referral from Home Health Service to Community Care

1. Upon determination that a patient may be appropriate for Community Care Services, the agency should:

   Notify the local Area Agency on Aging Community Care Assessment team for a telephone screening before the 75 visit limit is exhausted;

Rev. 4/00

   b. Request the patient be assessed by the care coordination team for CCSP services.

2. If approved for service by the care coordination team, the patient will be admitted to CCSP (contingent on availability of CCSP funds). The care coordinator will notify a home health agency currently enrolled in CCSP to arrange for the necessary services.

B. Referral From Community Care to Home Health Services Under CCSP

Rev. 4/00

1. After admission to CCSP the Care Coordinator will broker home health services to the patient who requires these services. Home health agencies must be currently enrolled as a CCSP provider to render these services to CCSP patients;

Rev. 4/00

2. The care coordinator requests the specific service and frequency for home health services under the direction of the physician.

3. When the CCSP enrolled home health agency accepts the referral, the care coordinator sends a standard admission packet to the agency;

4. The agency sends a Community Care Notification Form (CCNF) to notify the CCSP care coordinator of the date services began. The care coordinator generates a Service Authorization Form (SAF) to authorize services;

5. The CCSP enrolled home health agency uses the CCNF to notify the care coordinator prior to the patient exhausting the 75th home health visit. The care coordinator will generate and forward a new SAF to authorize visits beyond the first 75.

6. The CCSP enrolled home health agency uses the CCNF to report significant changes in the patient condition to the CCSP care coordinator.

Rev.4/03

> Note: For CCSP members, the provider uses the Level of Care page and CCSP care plan. Whether the visit is within the first 75 or is the 76th visit or greater, the area coordinator manages and authorizes the home health Service on the SAF.

Rev. 4/00

805. Independent Care Waiver Program (ICWP) Traumatic Brain Injury (TBI) Referrals

A. Referral from Home Health Service to Independent Care Waiver

1. Upon determination that a patient may be appropriate for Independent Care Waiver services, the agency should:

Rev. 4/00

a. Assist the patient to contact the Georgia Medical Care Foundation (GMCF) to initiate the intake information process before the 75th visit limit is exhausted;

b. GMCF will conduct a face-to-face assessment of the patient to determine eligibility for ICWP services;

2. If the patient meets the eligibility criteria for ICWP services by GMCF and the Division, the patient will be admitted to ICWP (contingent on availability of ICWP funds) or placed on the waiting list for services. When the patient is admitted to ICWP, GMCF will assist the patient in selecting a case manager. The case manager will notify a home health agency currently enrolled in ICWP to arrange for the necessary services.

B Referral from Independent Care Waiver Services to Home Health Services

1. After admission to ICWP, GMCF will develop and approve the Initial Plan of Care (POC) to include home health services to the member who requires these services.

Rev. 4/03

The case manager assists the member in selecting service providers and develops the Individual Plan of Care, indicating the specific service and frequency approved on the Initial Plan of Care and submits the Individual Plan of Care to GMCF for authorization.

2. GMCF and the case manager will refer the member to a Home Health Agency and provide the agency with a copy of the approved Initial Plan of Care and authorized Individual Plan of Care.

Rev. 4/03

Rev. 4/00

3. The agency follows the policies and procedures outlined in Chapters 700 and 900for ICWP members receiving the first seventy-five (75) home health visits. A copy of the approved Initial Plan of Care and authorized Individual Plan of Care must be submitted to the home health agency with the referral.

4. The home health agency must notify GMCF and the case manger prior to the patient exhausting the 75th home health visit. GMCF will refer the member to a home health agency currently enrolled in ICWP to provide the home health visits for the 76th visit and beyond. The home health agency must follow the policies and procedures outlined in the ICWP manual.

Rev. 4/03

Rev. 1/01

Note: All services must be identified in and coordinated around the Initial Plan of Care approved by GMCF. No home health service shall be reimbursed which is not listed on the approved Initial Plan of Care and authorized Individual Plan of care.

PART II - CHAPTER 900

SCOPE OF SERVICES

Rev. 4/03
Rev. 7/99 4/00

900. The following services are covered in the Home Health Services program when provided to eligible members in their place of residence and when such services have been ordered by a physician in a plan of care.

Rev. 7/99

> NOTE: Members must meet the eligibility criteria established in Chapter 700, Section 701.1 of this manual in order to receive home health services.

901. Skilled Nursing Services

Skilled nursing services, as outlined in the Official Code of Georgia Annotated (O.C.G.A.) Section 43-26-1, are covered on a part-time or intermittent basis.

901.1 Nursing services must be medically reasonable and necessary for treatment of an illness or injury based on the member's unique condition and individual needs and must be performed by a registered nurse in accordance with the plan of care. In certain cases, some skilled nursing services may be provided by a LPN under the supervision of the registered nurse. In determining whether a service must be performed by a registered nurse, consideration must be given to the inherent complexity of the services, the condition of the patient, and the patient's needs. There are other instances where the nature of the service and the condition of the patient will affect whether the services can only be performed safely and effectively by a registered nurse. For example, giving a bath is not a covered nursing service unless the patient's condition is so severe that it would be unsafe for the service to be performed by anyone other than a registered nurse.

Rev. 1/01

A. Services Which May Be Provided By A Registered Nurse Include but are not limited to:

1. Initial evaluation visit;
2. re-evaluation of patient's nursing needs;
3. initiation of plan of care and necessary revisions;
4. initiation of appropriate preventive and rehabilitative nursing procedures;

5. preparation of clinical and progress notes;

6. coordination of services;

7. informing the physician and other personnel of changes in the patient's condition and needs;

8. patient and family teaching; and

9. supervising and teaching other nursing personnel.

B. Services Which May Be Provided By A Licensed Practical Nurse (LPN) Include: Any services in accordance with and outlined in the Official Code of Georgia Annotated (O.C.G.A), Section 43-26-30 through 39.

C. Services Which May Not Be Provided By A Licensed Practical Nurse (LPN) include:

1. the initial evaluation visit;

2. initiation of the plan of care; or

3. home health aide supervisory visits.

901.2 Request for Skilled Nursing Services

Rev. 4/03 Justification and medical necessity for skilled nursing visits must be clearly documented in the home health certification and Plan of Care ordered by the attending physician and meet the Division's provision for skilled nursing care. The Plan of Care must be specific to the patient's diagnosis and reflect specific nursing interventions. Vague and general descriptions are not acceptable as sole justification for such services.

Rev. 1/01 Skilled nursing services will not be covered for members who received skilled nursing services under Medicare and have been discharged as stable.

Rev. 4/03 Provision of skilled nursing services should adhere to medical necessity according to the following:

Rev. 1/99

1/01 A. Nursing visits ordered by the physician for observation and assessment of a member's condition are covered at the Division's discretion on a limited and short-term basis when documentation indicates complications or developments of further acute episodes would develop requiring the physician or nurse's service to evaluate the need to change the plan of care. If a member's

condition remains stable or where there is evidence that the condition has a long-standing pattern, nursing visits for observation and assessment will not be covered. Members or family members must be taught to observe for signs and symptoms of possible complications which should be reported to the physician or the nurse.

Frequent visits when no changes are anticipated will not be covered.

Conditions which may justify observation and assessment services as described above include, but are not limited to:

1. Angina
2. Malabsorption Syndrome
3. Hypokalemia, Hyperkalemia, Hyponatremia
4. Crohn's Disease
5. C.O.P.D.
6. Ulcerative Colitis
7. Dehydration
8. Fecal Impaction
9. Renal Diseases
10. Hypertension - Document most recent blood pressure reading (within previous 30 days) on DMA-44.
11. Congestive Heart Failure

B. Skilled nursing visits for management and evaluation of the patient's care plan are covered at the Division's discretion on a limited and short-term basis where multiple underlying documented conditions and complications exist requiring that only a registered nurse can insure that essential nonskilled care is achieving its purpose. The complexity of the necessary unskilled services which are a necessary part of the medical treatment must require the involvement of skilled nursing personnel to promote the patient's recovery and medical safety based on the patient's overall condition. Documentation describing the complex care must be included in the plan of care.

C. Skilled nursing visits for teaching or training activities are covered at the Division's discretion on a limited and short-term basis when the teaching and/or training is appropriate to the member's functional loss, illness, or injury. Teaching and/or training activities must include a time frame in the plan of care when goals will be accomplished. Documentation in the medical record of teaching and/or training activities must reflect the member's or caregivers ability to comprehend and progress. Reteaching and/or retraining

Rev. 1/99

1/01 for an appropriate period may be covered at the Division's discretion on a limited and short-term basis when there is a change in caregivers, the procedure, or the member's condition that requires reteaching, or where the patient, family or caregiver is not properly performing the task. Teaching and/or training activities will not be covered when the patient, family or caregiver will not or is not able to learn or be trained. Documentation on the DMA-44 and plan of care must reflect the member and/or caregiver's ability to comprehend and progress.

Rev. 1/99 Teaching and training activities which require the skill of a licensed nurse include, but are not limited to the following:

1. Self-administration of injectable medications or a complex range of medications;

2. diabetic teaching;

3. self-administration of medical gasses;

Rev. 1/01 4. complex wound care;

Rev. 1/99 5. ostomy care;

6. self-catheterization;

7. self-administration of enteral feedings;

8. care and maintenance of intravenous or central lines and administration of medications through such lines;

9. bowel and bladder training;

10. performance of the activities of daily living when the member or care giver must use special techniques and adaptive devices due to a loss of function;

11. safe transfer techniques;

Rev. 1/99 12. proper body alignment and positioning and turning techniques of a bed-bound member;

13. ambulation with prescribed assistive devices (such as crutches, walker, cane, etc.) that are needed due to a recent functional loss;

Rev. 1/99 14. prosthesis care and gait training;

15. use and care of braces, splints and orthotics and associated skin care;

16. proper care and application of any specialized dressings or skin treatments;

17. preparation and maintenance of a therapeutic diet; and

18. proper administration of oral medication, including signs of side-effects and avoidance of interaction with other medications and food.

Rev. 1/00 Rev. 1/01

D. Skilled nursing visits for the administration of medications (intravenous, intramuscular, or subcutaneous injections and infusions) for safe and effective treatment of an illness or injury are covered when appropriate to the treatment of an illness, injury or functional loss of a member and the caregiver is unable to learn or perform the procedure.

Rev. 4/03 Rev 1/99 Rev. 4/00 Rev. 1/01

1. An agency providing this skilled nursing service must document in the Plan of Care the reason for the member or caregiver's inability to administer the medication and/or the reason for the non-availability of a care giver. When a caregiver is in the home, the documentation must indicate the reason the care giver is not able to administer the medication. The agency must specify the individual who will be responsible for administering the medication during the RN's absence. The plan of care must indicate a time frame when the member or caretaker will administer the medication independently. This includes administering insulin or prefilling insulin syringes.

Rev. 4/03 Rev. 1/01

Skilled nursing services for newly diagnosed diabetics for administration of medications must include the results of a fasting blood sugar (FBS) obtained by venipuncture in the Plan of Care thirty (30) days from the start of care date. Fasting blood sugar values obtained by glucometer testing will not be accepted. Refer to Section 901.2 (H) for the policy on skilled nursing visits for venipuncture.

Rev. 1/99

Nursing visits to perform glucometer testing are not covered as it does not require the skill of a nurse to perform these tests.

Rev. 1/99

2. Administration of Vitamin B-12 injections is medically necessary for a limited number of medical conditions.

   Conditions include, but are not limited to:

   (a) Pernicious Anemia;
   (b) Megaloblastic Anemia;
   (c) Fish Tapeworm Anemia;
   (d) Certain Gastrointestinal Disorders; or
   (e) Certain Neuropathies.

Rev. 10/01

3. Skilled nursing visits for the administration of Synagis injections for prevention of Respiratory Synctial Virus (RSV) are covered for high risk and prematurely born infants (26 to 36 weeks) and toddlers during the RSV season (September to April) up to the age of two (2) years old as approved by the Federal Drug Administration (FDA). Synagis is indicated for prevention of serious lower respiratory tract disease caused by respiratory synctial virus (RSV) in pediatric patients at high risk of RSV disease.

   Infants must meet one (1) or more of the following criteria to receive Synagis injections administered in the home by a Home Health Agency.

   A. Infants who have conditions that adversely affect respiratory function and who have required daily respiratory medications/treatments (e.g., oxygen, diuretics, bronchodilators, mechanical ventilation, etc.) within the last six (6) months and who are less than two (2) years of age at the onset of the RSV season;

   B. Infants born at less than thirty-two (32) weeks gestation who are less than six (6) months old at the onset of the RSV season;

   C. Infants born at thirty-two to thirty-five (32-35) weeks gestation who are less than six (6) months old at the onset of the RSV season and who have at least one (1) environmental risk factor (passive tobacco smoke exposure, day care, siblings, persistent hospitalization on an inpatient basis); or

   D. Infants less than two (2) years of age at the onset of RSV season whom are symptomatic and/or require day medications for congenital heart disease.

Rev. 10/01

Skilled nursing visits for Synagis injections are not covered for children over the age of two (2) and do not meet the established criteria.

Rev. 4/03

Rev. 1/99

E. Skilled nursing services associated with home phototherapy for members with neonatal jaundice (hyperbilirubinemia) will be reimbursed within the first thirty (30) days of life when a Durable Medical Equipment Company does not provide the phototherapy service (all inclusive of equipment, related supplies and a certified nurse). An agency providing skilled nursing services associated with home phototherapy must document the name of the equipment vendor in the Plan of Care. The physician is responsible for assessing the appropriateness of home phototherapy and for determining the length of time the infant is to be under the lights based on serum bilirubin levels and clinical condition of the infant.

The maximum fee is the home health agency reimbursable rate, all inclusive of the phototherapy equipment, related supplies, and a certified nurse to collect a daily bilirubin level. Coverage is for a maximum of four (4) consecutive days. Phototherapy service may not be provided and billed in the Durable Medical Equipment program when provided in the home health program. The home health agency must assure that the parent or caregiver is trained in the safe and effective use of the home phototherapy equipment.

The Division does not reimburse for home phototherapy until the member is discharged from the hospital.

F. Skilled nursing visits for venipuncture are covered when the collection of the specimen cannot be performed in the course of regularly scheduled absences from the home and is necessary for the monitoring of therapeutic blood levels of medications, monitoring of blood counts and electrolyte levels when affected by the member's medication regimen, and related to the member's illness or medical condition.

Rev. 4/03

1. Documentation of lab values for the previous three (3) months must be contained in the Plan of Care. If the member is a new home health patient, documentation of one (1) lab result within the previous thirty (30) days from the start of care date must be contained in t the Plan of Care.

2. When lab values are within the normal limits of accepted values for three (3) consecutive specimen collections, skilled nursing visits for venipuncture will no longer be covered.

Rev. 4/00

G. Skilled nursing visits for the administration of oral medications, eye drops/creams, topical ointments/creams, vaginal and/or rectal suppositories/creams, and filling of medicine packs are not covered. Exceptions are only granted in specific circumstances at the Division's discretion. Factors considered in granting an exception include, but are not limited to:

1. Patient and/or caregiver unable to provide the care due to a function physical motor impairment;

2. Mental impairment;

3. Complexity of the patient's medical condition;

4. Nature and number of medications prescribed; and

5. Complexity of a surgical procedure for which care is ordered.

Rev. 4/03

Documentation in the Plan of Care must include the specific circumstances that require a licensed nurse to administer medications of this type and/or fill medication packs. A timeframe indicating when the patient and/or caregiver will be able to administer these type medications or treatments must be included on the Plan of Care.

Skilled nursing visits to assess and monitor medication compliance are not covered in the home health program.

H. Provision of intermittent or part-time skilled nursing services for the preceding services are covered as defined. The following conditions and services are covered at the Division's discretion:

1. Nasogastric tube and percutaneous tube feedings (including gastrostomy and jejunostomy tubes), replacement, adjustment, stabilization, suctioning and teaching;

Rev. 1/99

2. nasopharyngeal and tracheostomy aspiration

3. Catheter care (urethral or suprapubic) insertion and replacement (every 30 days for Foley or 60-90 for silicone catheters) and irrigation;

4. ostomy care and providing immediate post-operative care;

Rev. 1/99

5. wound care when the skills of a licensed nurse are needed to provide safely and effectively the services necessary to treat the illness or injury;

Rev. 1/99

6. heat treatments

7. initial phases of regimen involving the administration of medical gases;

8. rehabilitative nursing procedures; and

Rev. 1/01

9. insertion, removal, and maintenance of intravenous access devices.

902. Home Health Aide Services

Rev. 1/99 Rev. 4/00 Rev. 10/01

Home health aide services are covered when the member has a moderate to severe functional physical impairment related to the member's illness or medical condition resulting in the limited ability or inability of the member to perform instrumental activities of daily living (IADL's) such as dressing and undressing, management of clothing, elimination, grooming, hygiene, mobility, ambulation, ability to prepare and eat meals, and ability to administer medications properly. The limited ability or inability of a member to perform grooming and bathing tasks alone does not necessitate the use of home health aide services. Services must be provided in accordance with the plan of care, with written instructions for patient care and supervision provided by a registered nurse or therapist as appropriate.

Rev. 4/03

Rev. 4/00 Rev. 10/01

1. Documentation must be provided in the Plan of Care of the member's functional physical impairment and the level of current functioning when performing instrumental activities of daily living (IADL's).

Rev. 4/00

2. The Plan of Care must include a time frame when goals for performance of instrumental activities of daily living (IADL'S) will be met.

Rev. 1/99

Home health aide services will not be covered for members who received home health aide services under Medicare and have been discharged as stable.

Rev. 1/01

Home health aide services may be provided directly by the home health agency or by contractual arrangement.

902.1 Services Which May Be Provided By A Home Health Aide Include:

A. Personal care (e.g., bath, hair shampoo, special foot care);

B. performance of simple procedures as an extension of therapy services such as range-of-motion exercises and ambulation assistance;

C. assistance with (not administration of) medications that are ordinarily self-administered and have been ordered by the physician;

D. reporting of changes in the patient's condition and GHP;

E. completion of appropriate records; and

F. incidental household chores which are essential to the member's health care at home (e.g., preparation and service of therapeutic meals, dusting for patients with respiratory ailments, and changing bed linens for incontinent patients).

902.2 Supervision of the Home Health Aide

A registered nurse must make a supervisory visit to the patient's residence at least once every two (2) weeks. Two weeks is defined as fourteen (14) calendar days. If the fourteenth day of the two-week period falls on a Saturday, Sunday or legal holiday, the supervisory visit must occur on the Monday immediately following or in the case of a holiday, the next business day to be in compliance with the policy. The purpose of the supervisory visit is to determine whether treatment goals are being met and assure that quality patient care is being rendered.

The supervisory visit will cover the two-week period preceding the visit. The supervisory visit may include observation of the home health aide.

Rev. 1/99

When only home health aide services are being furnished to a patient, a registered nurse must make a supervisory visit to the patient's residence at lease once every sixty (60) days. If the sixtieth day falls on a Saturday, Sunday, or legal holiday, the supervisory visit must occur on the Monday immediately following or in the case of a holiday, the next business day to be in compliance with the policy. When utilizing this supervisory frequency, the supervisory visit must occur when the aide is furnishing patient care. The supervisory visit will cover the sixty (60) day period immediately preceding the visit.

When only physical, speech or occupational therapy is furnished in addition to the home health aide, a skilled therapist may make the supervisory visit in place of the skilled nurse.

A record of the supervisory visit must be dated and documented by an R.N. (or a physical, speech or occupational therapist in allowable situations) in a narrative note in the patient's clinical record.

Any home health aide services rendered outside the supervisory period are non-reimbursable and must not be billed to the Division. Costs incurred for the registered nurse, physical therapist, speech therapist or occupational therapist visits to evaluate, supervise, or instruct home health aides are considered administrative costs and are not separately reimbursable as a visit.

903. Therapy Services

Physical, speech and occupational therapy services may be provided by the home health agency directly or under contractual arrangement. These services may be provided by a licensed therapist or a licensed therapist assistant supervised by a licensed therapist in accordance with the plan of care specifying the amount, frequency, and duration of the procedure and modalities to be used. When services are provided through contract with another entity, the home health

Rev. 1/01

agency must retain administrative and supervisory responsibility for the delivery of these services. Therapy services rendered by individually enrolled therapists, or through the Children's Intervention Services (CIS) Program or through the Children's Intervention School Services (CISS) program are not reimbursable under the home health program.

Rev. 1/99
Rev. 1/01

Therapy services will not be covered for patients who obtained therapy services under Medicare and have been discharged as stable.

903.1 Services Which May Be Provided By A Licensed Physical, Speech or Occupational Therapist Include:

A. Assisting the physician in evaluating the patient's level of functioning;

B. developing the plan of care and making routine revisions as needed;

C. preparing progress notes on a timely basis for their discipline; and

D. advising and consulting with other agency personnel regarding changes in the patient's condition.

All services rendered by a licensed therapist must be necessary for the patient's condition and be necessitated by a level of complexity that requires such services be performed by a licensed therapist or licensed therapist assistant under the supervision of a licensed therapist. A maintenance program shall be developed for the performance of simple procedures which could be safely and effectively provided by the member, family or home health aide.

903.2 Physical Therapy Services Include:

A. Therapeutic exercise programs including muscle strengthening, neuromuscular facilitation, sitting and standing balance and endurance, and increased range of motion;

B. gait evaluation and training; and

C. transfer training and instructions in care and use of wheelchairs, braces, prostheses, etc.

903.3 Speech Therapy Services Include:

A. Evaluating and recommending appropriate speech and hearing services;

B. providing necessary rehabilitative services for patients with speech, hearing or language disabilities; and

C. providing instructions for the patient and family to develop and follow a speech pathology program.

903.4 Occupational Therapy Services Include:

A. Teaching skills that will assist the patient in the management of personal care, including bathing, dressing, and cooking/meal preparation;

Rev. 1/01

B. assisting in improving the individual's functional abilities;

C. teaching adaptive techniques for activities of daily living; and

D. working with upper extremity exercises.

Services Which May Not Be Provided By A Therapist Assistant Include:

A. The initial patient evaluation; and

B. initiation of the plan of care.

903.5 Supervision of Therapist Assistant

A licensed therapist must be responsible for providing adequate supervision of the therapist assistant(s) at all times.

The licensed therapist must:

A. Meet with the assistant no less than once weekly to review all cases being treated;

B. document all meeting with the assistant;

C. make an on-site supervisory to each patient being treated by the assistant as appropriate based on the need to alter the treatment plan and no less than every sixth treatment;

D. document the on-site visits and indicate instructions given to the physical therapist assistant; and

E. be available to the assistant at all times for advice, assistance and instructions.

Costs incurred for licensed therapist visits to supervise a therapist assistant are considered administrative costs and are not separately reimbursable as a visit.

904. The Clinical Record

The home health agency must establish and maintain a current clinical record on all patients admitted to the agency that substantiates the services billed to Medicaid. These records must include at a minimum:

A. Appropriate patient identifying information including current directions to the patient's home;

B. name of patient's attending physician;

C. pertinent past and current findings;

D. a plan of care signed and dated by the attending physician at least every sixty-two (62) days or every two (2) months (or more often if patient's condition changes) which includes drug, dietary, treatment

E. signed and dated clinical notes written by the close of the business day immediately following the day the service was rendered by the providing member of the health team and incorporated no less often than weekly;

F. documentation reflecting home health aide services (if applicable), and supervision of aides every two (2) weeks;

Rev. 4/03

G. copies of summary reports sent to the physician at least every sixty-two (62) days or every two (2) months; and

H. a discharge summary when applicable.

904.1 Certification and Plan of Care

An individual plan of care must be developed for each patient in consultation with the agency staff and other attending professionals. The plan should address all pertinent diagnoses, mental status, types of service and equipment required, frequency of visits, expected duration of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications, treatments, safety measures, discharge planning, appropriate goals and other pertinent items. Orders for PRN services must be specific to a diagnosis and require the skills of a licensed health care professional. The total plan of care is reviewed by the attending physician and the home health personnel as often as the severity of the patient's condition requires.

The plan of care certifies the need for continuation or discontinuation of home health services. This must be done at least every sixty-two (62) days or every two (2) months. Drugs and treatments are to be administered by agency staff only as ordered by the physician. The nurse or therapist must record and sign verbal orders and obtain the physician's signature. **THERE IS NO SUBSTITUTE FOR THIS PLAN OF CARE.**

904.2 Clinical Notes

The clinical record must include clinical notes written after each visit or contact with the patient. The notes should be incorporated into the record weekly. These notes should be written by appropriate personnel providing the service(s). These written notes should include all information pertaining to the patient. Any problems reported by a patient or family must be addressed in these notes. Clinical notes must be maintained on a continuous basis and reflect on-going assessment of the patient's condition.

904.3. Summary Report

The summary report is a report of the patient's condition, change or progress, new problems identified, patient's vital signs, complaints, descriptions of wounds, etc. It must reflect the need for continuation or adjustment of services rendered. The summary report must be sent to the physician at least every sixty-two (62) days or every two (2) months and should reflect the need for re-certification of the plan of care or the termination of services. The summary report must address each service rendered. The Division or its designee has the right to periodically review the need for continuation of services.

Rev. 1/01

905. <u>On-Site Reviews and Audits</u>

In order to insure compliance with the policies and procedures set forth in this manual, representatives of the Division will conduct on-site reviews and audits of home health agencies enrolled with the Division. The reviews and audits will be conducted to determine whether services provided have been accurately and completely reported, whether all services reported have been performed and whether the services provided meet currently accepted standards of quality. The on-site reviews will include but are not limited to in-agency reviews of clinical and billing records and in-home patient assessments.

The Division generally will try to provide twenty-four (24) hour notice prior to on-site reviews or audits; however, on-site reviews and audits may be done with no prior notice.

Reports of the on-site reviews and audits will be forwarded to each agency by the Division. Upon receipt of the report, each agency will have twenty (20) calendar days from the date of the report to respond to the on-site review. Failure to comply with the provisions of this manual may lead to adverse actions including suspension or termination from the program. Audit response time will be outlined in the cover letter which will accompany the audit report.

The Division has no objection to agency personnel accompanying the Divisional representative(s) on home visits; however, the following guidelines must be observed:

A. DMA representative and agency personnel will travel in separate cars;

B. time and place of visits are at the total discretion of the DMA representatives; and

C. agency personnel must not interfere with the interview process.

906. <u>Non-covered Services</u>

The following are non-covered services in the Home Health Program:

A. Medical Social Services;

B. use of home health aide for chore services;

C. Meals-on-wheels;

D. audiology services;

E. private duty nurses;

F. efforts made by home health agencies to render services to patients not at home;

G. services provided without a physician's authorization;

Rev. 10/01

H. services that are not contained in the plan of care;

Rev. 1/99

I. skilled nursing and home health aide services to members receiving Model Waivered Services or Exceptional Children's Services;

J. services rendered to a member receiving medical day care services under the Waivered Home Care Program;

Rev. 1/99

K. therapy services rendered to a member receiving physical, speech or occupational therapy by an individually enrolled therapist or through the Children's Intervention Services Program or through the Children's Intervention School Services program;

L. services rendered to an individual receiving Medicare covered home health services;

Rev. 7/99

M. phototherapy services (all inclusive of equipment, supplies and skilled services) when provided and reimbursed in the Durable Medical Equipment program;

Rev. 4/03

N. services rendered which fail to comply with all terms and conditions of the provider's Statement of Participation and the provisions of this manual;

Rev. 4/03

Rev. 7/99 1/99, 1/01 Rev. 10/01

O. newborn teaching and assessment and Health Check type visits;

Rev. 7/99 Rev. 1/99

P. Postpartum follow-ups and assessments;

Rev. 7/99

Q. Home Health Services for social issues;

Rev. 4/00
R. Home Health Services to monitor and assess compliance with the treatment regimen;

Rev. 4/03
S. Skilled nursing visits to assess and monitor medication compliance; and

Rev. 4/03
Rev. 10/01
T. Skilled nursing visits to children greater than two (2) years of age for administration of Synagis.

PART II - CHAPTER 1000

BASIS FOR REIMBURSEMENT

1001. Reimbursement Methodology

Each home health agency is reimbursed a specific rate per visit for covered services. The specific rate per visit is based on the total of the agency's inflated base rate, any efficiency incentive applicable to the agency and a supply rate. The base rate, efficiency incentive and supply rate is subject to ceilings. Effective for dates of service July 1, 2003, reimbursement rates will be reduced by 10%. Rates, incentives, and ceilings are determined as follows:

a) Each agency's base rate is calculated using data contained in the as-filed or audited Medicaid cost report for that agency's base period. An inflation percentage is applied to the base period data and the resulting inflated base period cost per visit is the agency's base rate. The inflation percentage and base period are set by the Division.

b) Each agency is classified into one of the following categories: hospital-based, freestanding urban, and freestanding rural (see Section 1005). For each category the 75th percentile of inflated base period cost per visit is determined. This amount is the base rate ceiling for agencies in that category.

c) An efficiency incentive may be added to the base rate for an agency as follows:

   If an agency's base rate is less than or equal to the base rate ceiling in the agency's category, the difference between the base rate and the ceiling is multiplied by 20%, and the product (not to exceed $1.76) is added to the base rate. The total of base rate plus incentive shall not exceed the base rate ceiling for the agency's category.

d) The supply cost per visit for each agency is based on data contained in the as-filed or audited Medicaid cost report for that agency's base period. An inflation percentage is applied to base period data to determine each agency's inflated supply cost per visit. The inflation percentage and base period for supply costs are set by the Division.

   Inflated base period supply costs per visit for all agencies are arrayed on a statewide basis and the 75th percentile cost from that array is the supply rate. The supply rate is added to each agency's base rate plus any applicable efficiency incentive.

e) The reimbursement rate for each freestanding agency will be calculated as noted in paragraphs (a) through (d), and shall not exceed the base rate ceiling for that agency's category plus the supply rate.
The reimbursement rate for each hospital-based agency will be calculated as noted in paragraphs (a) through (d), and shall not exceed the maximum rate noted in paragraph (f) below.

f) For purposes of setting the maximum rate per visit for hospital-based agencies, the Division has established two sub-categories: urban hospital-based and rural hospital-based. The maximum rate per visit for each agency in these sub-categories is determined by adding a hospital-based adjustment amount to the freestanding urban and freestanding rural base rate ceilings. The adjustment amount is calculated as follows:

The mean of the agencies' inflated base period cost per visit will be calculated for each of the sub-categories. A percentage of the mean for each sub-category will be calculated and added to the base rate ceiling for the corresponding freestanding urban or rural category, plus the supply rate to establish the maximum rate per visit for hospital-based agencies in either the urban hospital-based or rural hospital based sub-category.

Each hospital-based agency will be reimbursed the lesser of its rate calculated as noted in paragraphs (a) through (d), or the maximum rate per visit for its sub-category, as described above.

Assignment to a sub-category is determined according to the criteria outlined for classification of agencies in Section 1005; this section also contains the definition of urban, rural and hospital-based.

g) Reimbursement rates will be adjusted for home health agencies which provide certain home-delivered services to community-care members. The rate adjustment will be calculated using the home health reimbursement methodology in paragraphs (a) through (f) above, and the calculation will include both home health and home delivered services utilization data for the base period.

Reimbursement rates will be adjusted only for those agencies currently enrolled and providing services in the community care home-delivered services program and for which at least nine months of cost and utilization data exists for the base period. Home health agencies which discontinue the provision of home-delivered services will be subject to a reduction in their reimbursement rate.

h) Effective for dates of service July 1, 1994, and after, a $3.00 member copayment is required for all home health visits.

Members who may be subject to the copayment will be identified on the Eligibility Certification (Medicaid card). (See Appendix J)

1001.1 Cost Reports

Each agency must submit to the Division two copies of its as-filed Medicare cost report and a completed Medicaid Cost Data Form (supplied by the Division). Each agency with a home office also must submit two copies of its as-filed Medicare Home Office Cost Report and the Medicaid Home Office Data Form.

Effective for cost reporting periods ending on or after June 27, 1995, these documents must be received by the Division within 150 days after each agency's fiscal year end. If all applicable Medicare and Medicaid reports have not been received after this 150 day period, a rate reduction of 10% on the current rate will be imposed. This rate reduction will remain in effect through the final day of the month in which the cost information is received. If the information is received after any fraction of a month beyond the 150 day period, the rate reduction of 10% will be applied for the entire month.

If an agency's cost information is not received by the time the Division establishes individual provider rates and determines the percentiles and rate ceilings, that agency will be assigned the lesser of its current rate or the lowest rate in the State for the appropriate category, less applicable incentive, as established by the rate-setting process. If the agency's cost information is received after rates are established, the Division will calculate a rate based on the information received and retroactively and prospectively adjust the agency's previously assigned rate only if it is greater than the calculated rate. The agency's rate will remain in effect until the next rate adjustment period, as determined by the Division. Failure to submit cost information may result in suspension or termination of the agency from the Medicaid Home Health program.

An agency's Medicaid Cost Data Form and Home Office Cost Data are subject to review or audit by the Division or its agent(s) in accordance with HCFA-15 principles of reimbursement and Medicaid policies and procedures. The agency for which the rate was effective as a result of the review or audit reimbursement rate will be adjusted (if necessary) for the period performed. Percentile and rate ceilings as initially established will not be adjusted based upon subsequent audits. An agency may appeal any audit adjustments and rates resulting there from using the administrative review procedures outlined in Part I of this manual, Section 503 (see Section 1002).

For audit examinations described above, it is expected that a facility's accounting records, including its home office's accounting records where applicable, will be available within the State. Should such records be maintained at a location outside the State, the facility will be required to pay for travel costs incurred for any examination conducted at the out-of-state location.

1001.2 Nonallowable Costs

Effective for the determination of reasonable costs used in the calculation of rates initially established on and after April 1, 1991, the costs outlined below are nonallowable for Medicaid purposes:

Costs related to lobbying and government relations, including costs for employees with duties related to lobbying and government relations, honorariums and reimbursement of travel or other expenses of elected officials;

b) Memberships in civic organizations;

c) Out-of-state travel paid by the provider for persons other than board members or those employed or contracted by the provider. Out-of-state travel for provider personnel must be related to patient care;

d) Vehicle depreciation or vehicle lease expense in excess of the lesser of IRS limits per vehicle or the amount allowed under Medicare reimbursement principles; provided, however, such limits shall not apply to specialized patient transport vehicles (e.g. ambulances);

e) Air transport vehicles that are not used to transport patient care staff or patients. If these vehicles are sometimes used for patient care staff or patient transport, the portion of cost that is unrelated to patient transport is nonallowable;

f) Fifty percent (50%) of professional dues for national, state, and local associations.

g) Legal services for an administrative appeal or hearing, or court proceeding involving the provider and the Division or any other state agency when judgment or relief is not granted to the provider. Legal services associated with certificate of need issuance reviews, appeals, disputes or court proceedings are not allowable regardless of outcome. Legal services associated with a provider's initial certificate of need request shall be allowable.

h) Advertising costs that are (a) for fund-raising purposes, (b) incurred in the sale or lease of a facility or agency or in connection with issuance of the provider's own stock, or the sale of stock held by the provider in another corporation, (c) for the purpose of increasing patient utilization of the provider's facilities; (d) for public image improvement; or (e) related to government relations or lobbying.

Information on these non-allowable costs will be obtained by the Division or its agent at the time of review or audit of the agency, or in accordance with Part I, Subsection 106.19 of this manual.

1001.3 Cost Report Due Date Extension

An agency may request an extension of time for submission of the Medicare and Medicaid cost information beyond the revised due dates based on the 150 day period only by written request to the Division. Such request must be received prior to the due date of the cost report information and will be granted only if the provider's operations are "significantly adversely affected" because of the circumstances beyond the provider's control (i.e., a flood or a fire that causes the provider to halt operations).

A request for extension must include a copy of any extension granted by the Medicare intermediary, and the reason(s) an extension is being requested. The Division will review each written extension request and, if approved, will specify the revised due date of the cost information. If the cost information is not received by this revised date, an agency's rate will be reduced as described in Subsection 1001.1.The request for extension must be submitted to: Coordinator, George W. Anderson, Non-Institutional Reimbursement Section, P.O. Box 38440, Atlanta, Georgia 30334.

1001.4 New Agencies

a) A new agency will be reimbursed a rate equal to the statewide average reimbursement rate for the appropriate category, as of the effective date of enrollment of the new agency. This new agency rate will be reimbursed until a cost report for a base period (minimum nine months) on which an agency-specific rate per visit can be based, is received by the Division. There will not be a cash settlement determination for new agencies.

b) A new agency is defined as an agency established by the initial issuance of a Certificate of Need (CON), Medicare certification, and state license; it is reimbursed as described in paragraph a) above. An agency formed as a result of a merger, acquisition,

other change of ownership, business combination, etc., is not a new agency.

Each agency of this type will maintain the reimbursement rate it was assigned prior to the transaction. When rates are subsequently adjusted, the appropriate cost report for the base period (as determined by the Division) will be used as a basis for determining the agency's rate.

1001.5 Agencies with Insufficient or Unauditable Cost Data

If an existing agency submits cost data for its fiscal year that corresponds to the base period and the fiscal year is for an insufficient period of time (as determined by the Division but usually a period of less than nine (9) months), that cost data will not be used in establishing the percentile and rate ceilings for the appropriate category and in calculating the statewide supply rate per visit. However, the data will be used to calculate a rate per visit using the methodology in Section 1001. A free-standing agency's actual reimbursement rate in this instance will be the lesser of the calculated rate per visit (including applicable incentive) or the 75th percentile for the appropriate category, calculated exclusive of the agency's insufficient cost data, plus the statewide supply rate per visit, also calculated exclusive of the agency's insufficient cost data. A hospital-based agency's actual reimbursement rate in this instance will be the lesser of the calculated rate per visit (including applicable incentive) or the maximum rate per visit for the appropriate hospital-based subcategory, calculated exclusive of the agency's insufficient cost data, plus the supply rate per visit, also calculated exclusive of the agency's insufficient cost data. There will be no cash settlement for existing agencies with insufficient cost data for the base year.

Existing agencies with cost data which cannot be audited for the fiscal year that corresponds to the base period will be omitted from the rate setting process and assigned the lowest rate in the state for the applicable category until the appropriate records are made available to verify (audit) the cost information.

1001.6 Amended Medicare and Medicaid Cost Data

An agency may submit an amended Medicare cost report and Medicaid Cost Data Form after the initial submission for the most recent fiscal year. The amended report and form must be received by the Division no later than ninety (90) days after the due date of the initial report and form, or ninety (90) days after any due date extension granted by the Division pursuant to Subsection 1001.3. The amended Medicare report must support the amended Medicaid cost data form.

The due date of the initial report and form is contained in Subsection 1001.1.

Rev. 1/98

1001.7 Availability of Records

Providers using computerized information systems for accounting or other purposes must make this information available in a suitable electronic format if requested by the Division or its agents.

1002. Appeal of Reimbursement Rates

Providers may submit written appeals concerning their reimbursement rates as initially established, or as adjusted based upon an audit or review by the Division or its agents. Only the following will be accepted as a basis for appeal:

a) evidence that the cost report figures used to determine the base rate and supply rate contained an error on the part of the Division or its agents;

b) evidence that the Division made an error in calculating the agency's reimbursement rate; or

c) evidence that the Division is not complying with its stated policies in determining the base rate, incentive, or supply rate per visit.

In addition, an agency may submit written appeals concerning audit adjustments made by the Division or its agents as a result of on-site audits or desk reviews.

Rev. 4/03

An agency's appeal request must be submitted within thirty (30) days of the date of the rate notification and audit adjustments letter to: Director, Linda Mathis Non-Institutional Reimbursement Section, P. O. Box38440, Atlanta, Georgia 30334. The appeals process for reimbursement rates and audit adjustments will follow the administrative review procedures outlined in Part I of this manual, Section 503.

1003. Provider Return on Equity

The Division does not reimburse providers for return on equity.

1004. Physician Reimbursement

Rev. 4/03

The cost associated with the preparation and signing of orders and plan of care by a physician is a non-allowable cost and is not reimbursable under the Home Health program, nor are these services billable physician services since they are functions generally considered to be part of the usual physician/patient referral mechanism.

1005. Classification of Agencies

For reimbursement purposes home health agencies will be classified as follows:

a) Urban - An agency located in a Metropolitan Statistical Area as evidenced by documentation on file with the Division, including, but not limited to the address on the Medicare cost report received by the Division or the fiscal intermediary.

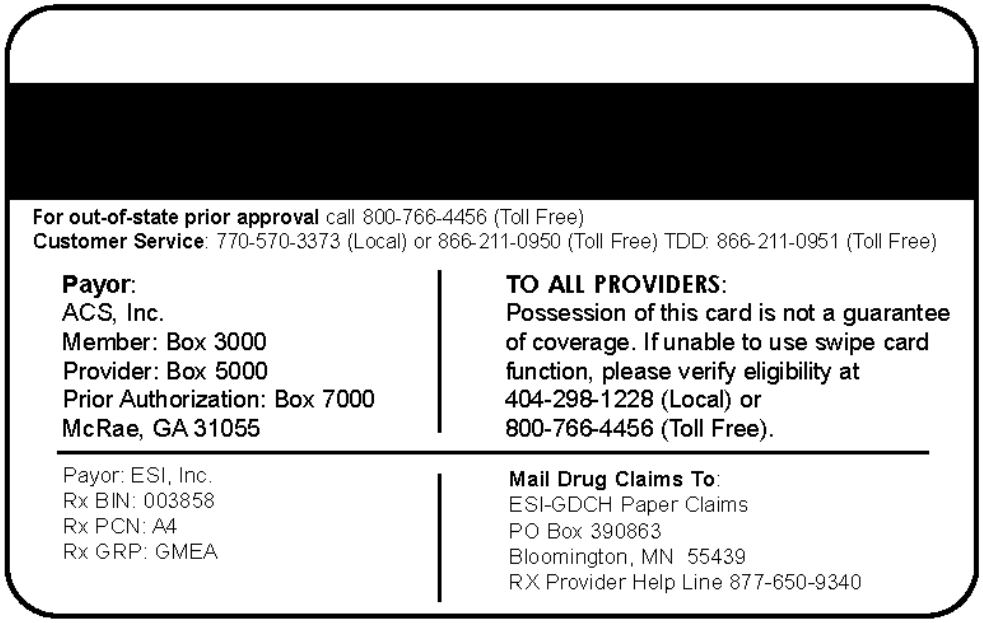
b) Rural - An agency located in a non-Metropolitan Statistical Area as evidenced by documentation on file with the Division, including, but not limited to the address on the Medicare cost report received by the Division or the fiscal intermediary.

c) Hospital-based - An agency classified as hospital-based for Medicare purposes will be considered hospital-based for Medicaid purposes. Hospital-based agencies will be further categorized as urban or rural using the criteria in (a) and (b) above. Agencies retroactively classified as hospital-based by Medicare will not be classified retroactively as hospital-based by the Division. The effective date of the classification for Medicaid purposes will be prospective and will be determined by the Division. The agency will be notified of the prospective effective date.

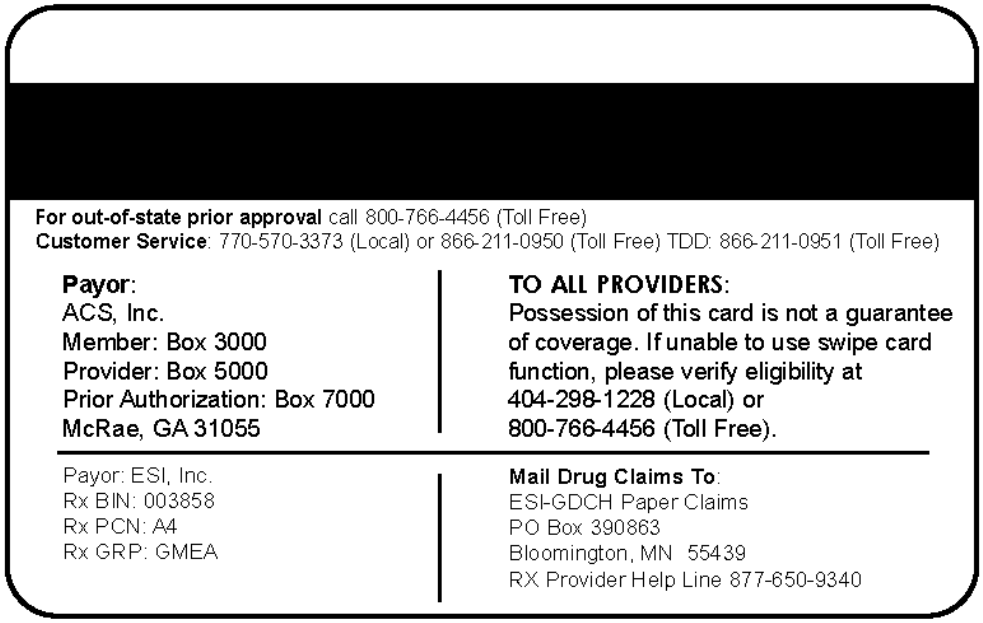
Agencies which submit Medicare cost reports with addresses different from the address on the Statement of Participation on file with the Division will have their cost reports returned for verification. If the agency uses the address on the Medicare cost report for Medicare purposes, this same address will be utilized in designation of a location for rate setting purposes for the Division.

APPENDIX A

Medicaid Member
Identification Card Sample



PeachCare for Kids Member
Identification Card Sample



APPENDIX B

DEFINITIONS

1. **CLINICAL NOTE** - A dated and signed written notation by the providing member of the health team of a contact with a patient containing a description of signs and symptoms, treatment and drugs given, the patient's reaction, and any changes in physical or emotional condition.

2. **DIVISION** - Georgia Division of Medical Assistance.

3. **PLAN OF CARE** - An individual plan written, signed, and reviewed at least every sixty-two (62) days or every two (2) months by the patient's physician prescribing items and services for the patient's condition.

4. **PROGRESS NOTE** - A dated and signed written notation by the providing member of the health team, summarizing facts about care and the patient's response during a given period of time.

5. **PHYSICIAN** - An individual who is currently licensed to practice medicine in the State of Georgia.

6. **DATE OF RECEIPT** - the date when the document is received by the Division or its contractor.

7. **DFCS** - Department of Family and Children Services.

8. **DHR** - Department of Human Resources.

9. **VISIT** - A personal contact in the residence of a patient made for the purpose of providing a covered service. One visit is counted each time a covered service is rendered in the patient's home. Dates of all home visits must be recorded in the patient's record.

10. **PRN** - A skilled visit provided outside the approved visit frequency. PRN must be in the Plan of Care and justified as reasonable and necessary in accordance with treatment for the specified diagnosis. PRN aide visits are not reimbursable.

APPENDIX C
HOME HEALTH COST DATA FORM (FREESTANDING)

PROVIDER NAME: _____

MEDICAID PROVIDER NUMBER: _____

COST REPORTING PERIOD - FROM:_____ **TO:**_____

I. VISITS BY DISCIPLINE	(1) Medicaid Home Health	(2) Agency Total
Skilled Nursing		
Physical Therapy		
Speech Therapy		
Occupational Therapy		
Home Health Aide		
Total		

(1) Enter information from agency's records.

(2) Enter information from HCFA Form 1728, Worksheet C, Cost Per Visit Computational, Part I, Column 3, Lines 1, 2, 3, 4, 5, and 6.

II. COST INFORMATION	(1) Agency Total Home Health
Skilled Nursing	
Physical Therapy	
Speech Therapy	
Occupational Therapy	
Home Health Aide	
Total	

Enter information from HCFA Form 1728, Worksheet C, Cost Per Visit Computational, Part I, Column 2, Lines 1, 2, 3, 4, 5, and 6.

III. MEDICAL SUPPLIES BILLED TO PATIENTS

(1) Total Agency Cost _____ (4) Medicaid Charges _____

(2) Total Charges _____ (5) Medicaid Cost _____
(RCC x Medicaid Charges)

(3) Ratio of Cost to Charges (RCC) _____

(1) (2) (3) Enter information from HCFA Form 1728 Worksheet C, Other Patient Services, Line 17, Columns 2, 3, and 4, respectively.
(4) Enter information from agency's records.

(Signed) _____
Officer or Administrator of Agency

_____
Title

_____
Date

DMA-601-FS (9/95)

APPENDIX D

HOME HEALTH COST DATA FORM (HOSPITAL-BASED)

PROVIDER NAME: _____

MEDICAID PROVIDER NUMBER: _____

COST REPORTING PERIOD - FROM: _____ **TO:** _____

I. VISITS BY DISCIPLINE

	(1) Medicaid Home Health	(2) Agency Total Home Health
Skilled Nursing		
Physical Therapy		
Speech Therapy		
Occupational Therapy		
Home Health Aide		
Total		

(1) Enter information from agency's records.

(2) Enter information from HCFA Form 2552, Worksheet H-5, Part I, Column 3, Lines 1, 2, 3, 4, 5, and 6.

II. COST INFORMATION

	(1) Agency Total Home Health
Skilled Nursing	
Physical Therapy	
Speech Therapy	
Occupational Therapy	
Home Health Aide	
Total	

Enter information from HCFA Form 2552, Worksheet H-5, Part I, Column 2, Lines 1, 2, 3, 4, 5, and 6.

III. MEDICAL SUPPLIES BILLED TO PATIENTS

(1) Total Agency Cost _____ (4) Medicaid Charges _____

(2) Total Charges _____ (5) Medicaid Cost _____

(3) Ratio of Cost to Charges (RCC) _____ (RCC x Medicaid Charges)

(1) (2) (3) Enter information from HCFA Form 2552 Worksheet H-5, Other Patient Services, Line 17, Columns 2, 3, and 4, respectively.
(4) Enter information from agency's records.

(Signed) _____
Officer or Administrator of Agency

_____
Title

_____
Date

DMA-600-HB (9/95)

APPENDIX E

Georgia Better Health Care Program Overview

The Program

Georgia Better Health Care (GBHC) is the Primary Care Case Management (PCCM) program for the State of Georgia. The objectives of this program are to improve access to medical care - particularly primary care services, enhance continuity of care through creation of a "medical home", and decrease cost through reduction of unnecessary medical services. Georgia Better Health Care operates as a statewide program under a managed care amendment to the state plan, replacing the 1915(b) waiver program, approved by the Centers for Medicare and Medicaid Services (CMS).

Primary Care Providers (PCPs)

Unique to Georgia Better Health Care is a process that matches Medicaid recipients to a Primary Care Provider (PCP). Through an on-going provider/patient relationship, the PCP provides and coordinates all health care services, including referrals for necessary specialty services, and maintains 24-hour availability to members. The primary care provider either provides directly or coordinates the delivery of covered health care services. These services may include general medical care, specialty care, dental and HEALTH CHECK services for children, or hospitalizations.

Physician participation in GBHC is open to general practitioners, family practitioners, pediatricians, general internists and gynecologists. Nurse practitioners who specialize in family practice, pediatrics or gynecology are also eligible to enroll as PCPs. While physician assistants may not enroll independently, they may enroll in GBHC as a member of a physician's practice. Physician specialists, public health department clinics and hospital outpatient clinics may enroll if they agree to the requirements of the PCP role described in Part II Policies and Procedures for Georgia Better Health Care Services, **§602.3**. Providers receive a monthly case management fee for each assigned member. Medicaid-covered services delivered by the PCP are reimbursed on a fee-for-service basis according to the regular Medicaid fee schedule.

During enrollment, members are given the opportunity to select a PCP. For those who do not make a selection, assignment is based on maintaining existing as well as historical provider/member relationships, to the extent possible. Lacking historical usage, the member is assigned based on age, sex and geographic proximity to the PCP.

GBHC Member Eligibility

Enrollment with a PCP in GBHC is mandatory for all Medicaid recipients with the exception of those listed in Part II, Policies and Procedures for Georgia Better Health Care, **§ 703**. GBHC members are recognized by the primary care information on their identification card that lists the provider name, address, and telephone number of the members PCP. Under plan name, Georgia Better Health Care will be listed. Member eligibility, including current PCP, should be verified for each date of service through the GHP Web Portal, the IVR system or the Customer Interaction Center.

GBHC Referrals

A referral is a request by a PCP for a member to be evaluated and/or treated by a different physician, usually a specialist. Referrals are required when a GBHC PCP refers a member to:

- A specialist for evaluation and/or medical care
- A provider who is "covering" for the PCP during periods of absence from the PCP setting (such as week-end coverage when the PCP is not in town)
- A HEALTH CHECK provider for HEALTH CHECK screening

Each referral entered will result in a unique number that must be placed on the claim form. Referrals are valid for 90 days from the effective date. The effective date is either the date the referral is entered, or it may be backdated up to thirty days to accommodate for coverage situations. A quick reference guide to GBHC referrals can be found in Part II, Policies and Procedures for Georgia Better Health Care Services, **Appendix R**.

Medicaid prior approval and preadmission certification requirements remain applicable to services delivered to Georgia Better Health Care members, unless specifically waived.

Services Exempt from Georgia Better Health Care Referral

Referrals are not required for ancillary services, diagnostic testing, DME, home health, emergency services, Individual Education Plan (IEP) Services or hospitalizations. Additional exemptions from GBHC Referral are:

Services delivered by providers enrolled in the following Medicaid programs:

- Anesthesiology Services (DMA Form 85 only)
- Community Care Services
- Dental Services (Excluding Oral Surgery)
- Dialysis Services
- Early Intervention Case Management
- Family Planning Services
- Health Department Services: Diagnostic, Screening & Preventive Services (DSPS)
- Hospice Services
- Independent Care
- Independent Laboratory Service
- Non-emergency transportation & Ambulance Services
- Nursing Home, ICF/MR, Swing Bed Services
- Optometry Services (Including eye glasses)
- Pathology (Interpretation and report)
- Pharmacy services
- Podiatry services
- Pregnancy related services
- Psychology and other Mental Health services
- Targeted case management
- Therapeutic residential intervention services
- Waivered home care

2. Services exempted from GBHC referral based on procedure or diagnosis code:

Hospital Emergency Department Services	
CPT Codes:	**99281**
	99282
	99283
	99284
	99285

Obstetrics & Family Planning	
CPT Codes:	ICD-9 Codes:
59000-59899	**630-676**
58300-58301	**V22-V37**
58600-58615	**760-779**
11975-11977	**FPF**
X9312 (Norplant Kit)	

Psychiatric Services	
CPT Codes:	**1-90871, M0064**
90842 & 90844 are non-covered Medicaid services M0064	

Foot Care Services (provided by medical doctor)	
CPT Codes:	**27600-29750**

Ophthalmology	
CPT Codes:	ICD-9 Codes:
92002-92499	**360-379**

The ordering provider will be responsible for obtaining any necessary Prior Authorizations or Preadmission Certifications. The ordering provider, if not the PCP, must have a valid referral from the PCP.

APPENDIX F

CO-PAYMENT

Effective with dates of service July 1, 1994, and after, the Division is implementing a $3.00 copayment for each home health visit.

The copayment does not apply to the following members:

- Pregnant women
- Members under 21 years of age
- Dialysis members
- Hospice care members

The copayment does not apply to the following services:

- Emergency services, and
- Family Planning services

The provider may not deny services to any eligible Medicaid member because of the member's inability to pay the copayment.

The provider should check the Eligibility Certification (Medicaid card) each month in order to identify those individuals who may be responsible for the copayment. The Eligibility Certification has been modified to include a copayment column adjacent to the date-of-birth section. When "yes" appears in this column for a specified member, the member may be subject to the copayment.

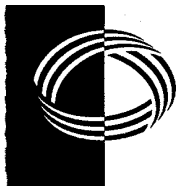
The Division may not be able to identify all members who are exempt from the copayment. Therefore providers should identify the members by entering the following indicators in field 24(I) of HCFA-1500 claim form:

P = Pregnant
S = Nursing facility members
H = Hospice
E = Emergency services

The fiscal agent will automatically deduct the copayment amount from the provider's payment for claims processed with dates of service July 1, 1994, and after. Do not deduct the copayment from your submitted charges. The application of the copayment will be identified on the remittance advice. A new explanation of benefit (EOB) code will indicate payment has been reduced due to the application of copayment.

Rev. 7/99

NOTE: See Section 1305. Reimbursement Note in Part II, Policies and Procedures for Home Delivered Services manual for clarification of cost-share requirements related to CCSP members.



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

NOTICE OF YOUR RIGHT TO A HEARING

You have the right to a hearing about this decision. **To have a hearing, you must ask for one in writing. You should send a copy of the attached letter** in **30 days or less** to this address:

Department of Community Health
Legal Services Section
Department of Medical Assistance
2 Peachtree Street, NW-40th Floor
Atlanta, Georgia 30303-3159

If you want to keep your services, you must send a written request for a hearing before the date that your services change.

The Office of State Administrative Hearings will notify you of the time, place and date of your hearing. An Administrative Law Judge will hold the hearing. In the hearing, you may speak for yourself or let a friend or family member to speak for you. You also may ask a lawyer to help you. You may be able to get legal help at no cost. If you want a lawyer to help you, you may call one of these numbers:

Georgia Legal Services Program
1-800-498-9469
(Statewide legal services, EXCEPT for the counties served by Atlanta Legal Aid)

Georgia Advocacy Office
1-800-537-2329
(Statewide advocacy for persons with disabilities or mental illness)

Atlanta Legal Aid
(404) 377-0701 (DeKalb/Gwinnett Counties)
(770) 528-2565 (Cobb County)
(404) 524-5811 (Fulton County)
(404) 669-0233 (So. Fulton/Clayton County)

State Ombudsman Office
1-888-454-5826
(Nursing Home or Personal Care Home)

You may also ask for free mediation services by calling 404-656-9090. Mediation is another way to solve problems without a hearing. If you cannot solve the problem with mediation, you still have the right to a hearing.

APPENDIX H

STATEMENT OF PARTICIPATION

The new Statement of Participation
is available in the Provider Enrollment Application Package.

Written request for copies should be forwarded to:

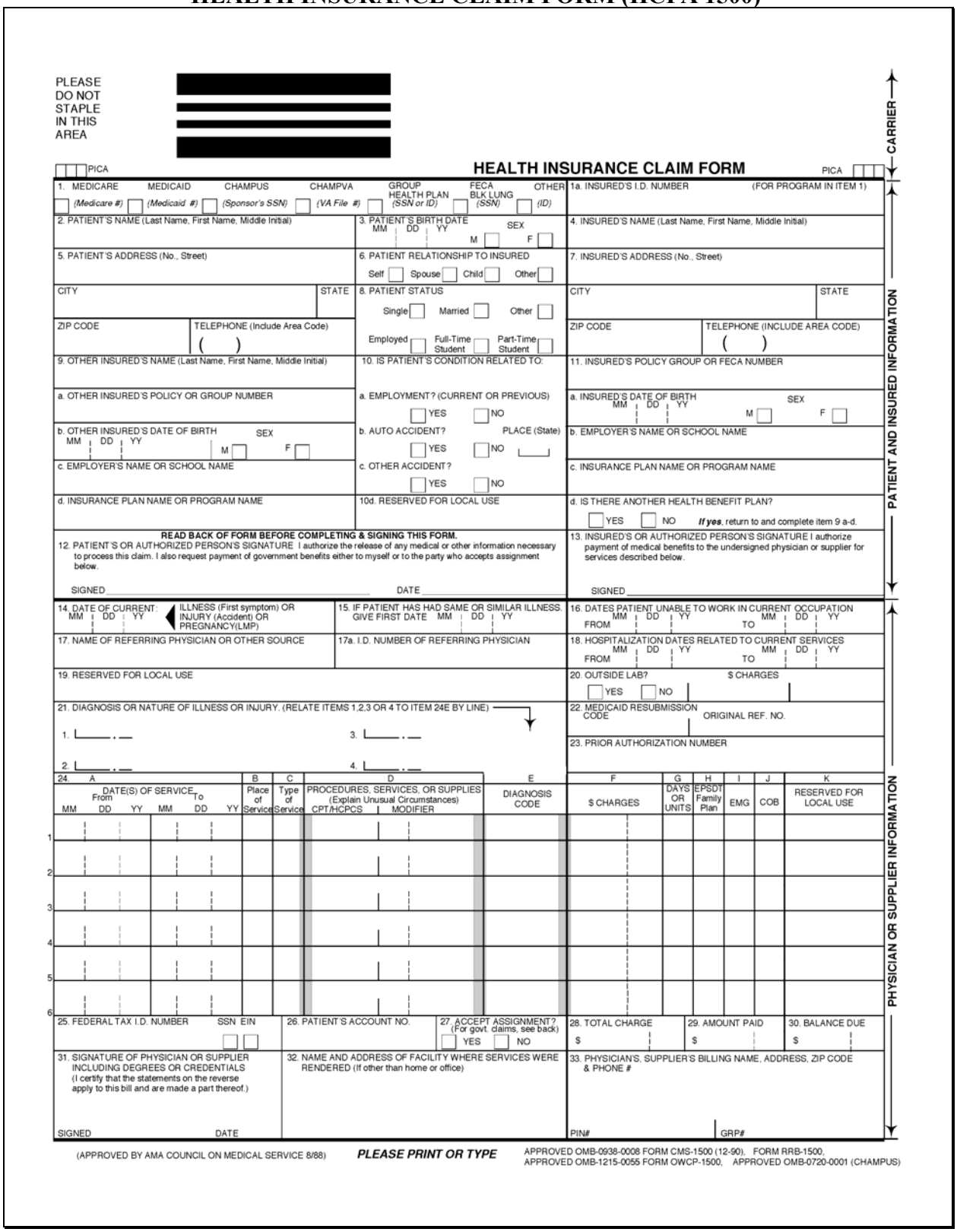
GHP
Provider Enrollment Unit
P.O Box 88030
Atlanta, GA 30356

OR

Phone your request to:

(404) 298-1228 or 1 (800) 766-4456
and choose option (#4)

APPENDIX I
HEALTH INSURANCE CLAIM FORM (HCFA 1500)



PLEASE DO NOT STAPLE IN THIS AREA

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

INSTRUCTIONS

The following table provides a brief description of the fields located on the CMS-1500 Form. The alphanumeric data located in the **Form Locator** column identifies the area / location of the field on the CMS-1500 Form. (Data is entered in this area on the form.) The data located under the **Field Name** identifies and names the field for the given location. The alpha character located in the **Required Field** denotes the following:

- R - Required
- C - Conditionally required/if applicable

The information located in the **Comments** area explains what you should enter in each field.

Form Locator	Field Name	Required Field	Comments
1.	Health insurance coverage	R	Check appropriate box for coverage.
1a.	Insured's ID number	R	Enter the member's Medicaid number exactly as it appears on the eligibility card, last name first.
2.	Patient's name	R	Enter Medicaid member's name exactly as it appears on the eligibility card, last name first.
3.	Patient's birth date and sex	C	Enter member's date of birth (using the MM/DD/YY format) and gender.
4.	Insured's name	C	Enter insured's name ONLY if other insurance (third party). Medicare is NOT considered other insurance.
5.	Patient's address	C	Enter member's full and correct address.
6.	Patient relationship to insured	C	Enter relationship, if applicable.
7.	Insured's address	C	Enter address, if applicable.
8.	Patient's status	R	Indicate marital status, if employed or if student.
9.	Other insured's name	C	Enter only if third party payer.
9a.	Other insured's policy or group number	C	Enter only if third party payer.
9b.	Other insured's date of birth and sex	C	Enter only if third party payer.
9c.	Employer's name/school name	C	Enter only if third party payer.
9d.	Insurance plan name or program name	C	Enter only primary insurance information, if Medicaid is secondary payer.
10a.	Is patient's condition related to employment?	R	Enter "X" if treatment related to employment.
10b.	Is patient's condition related to auto accident?	R	Enter "X" if treatment is related to auto accident.
10c.	Is patient's condition related to other accident?	R	Enter "X" if treatment is related to other accident.
10d.	Reserved for local use		
11.	Insured's policy group or FECA (?) number	C	Enter number of any other insurance plan, if applicable.
11a.	Insured's date of birth and sex	C	Enter date of birth and gender, if applicable. Enter date using MM/DD/YY format.

Form Locator	Field Name	Required Field	Comments
11b.	Employer's name/school name	C	Enter employer's name or school name, if applicable.
11c.	Insurance plan or benefit plan being billed	C	Enter insurance plan or program name, if applicable.
11d.	Other health benefit plan	C	Indicate whether another coverage or insurance plan exists. If "YES", the provider should complete items 9 – 9d on the HCFA-1500 form.
12.	Patient's or authorized person's signature and date	R	Enter the signature and date using the MM/DD/YY format.
13.	Insured or authorized person's signature	C	Enter signature, only if third party payer.
14.	Date of current illness, injury and/or pregnancy	R	Enter date in MM/DD/YY format. And, if for pregnancy, give date of LMP (?). *Note:* If "YES" is indicated in field 10a – 10c, enter an accident date for this field.
15.	Previous date of same or similar illness	C	Enter date in MM/DD/YY format, if applicable.
16.	Dates patient unable to work	C	Enter date in MM/DD/YY format, if applicable.
17.	Name of referring physician or other source	C	Enter name, if applicable.
17a.	Referring physician's ID number	C	Enter referring physician's Medicaid provider number, or Universal Provider Identification Number (UPIN) or state license number and if GBHC member, enter GBHC referral number, if applicable.
18.	Hospitalization dates	C	Enter hospitalization dates related to current services, using the "from-through" format, if applicable.
19.	Reserved for local use		
20.	Outside lab	C	Check "YES" or "NO" (charges are not necessary).
21.	Diagnosis or nature of illness or injury	C	Enter International Classification of Disease, 9th Revision, Clinical Modification (ICD-9 CM) code(s) related to service billed. List code(s) priority order (primary, secondary, and so forth.)
22.	Medicaid resubmission code/original reference number	C	Enter the Transaction Control Number (TCN) of the previous/original claim, if this is for an adjustment.
23.	Prior authorization number	C	Enter the prior authorization number or pre-certification number (PA/PC) issued by Georgia Medical Care Foundation (GMCF), if applicable.
24a.	Date(s) of service	R	Enter first date of service (DOS) in the "from" space and the last DOS in the "to" space. If services are only for one date, enter the date twice using the MM/DD/YY format. Claims for DOS spanning more than one calendar year (December 31 through January 1) or state fiscal year (June 30 through July 1) should be split in two so that the first claim bills for services in the old year and the second claim bills for services in the new year.
24b.	Place of service	R	Enter valid and appropriate two digit codes for place of service. The only valid POS code is 12.
24c.	Type of service	R	Enter valid and appropriate code(s) for type of service.

Form Locator	Field Name	Required Field	Comments
24d.	Procedure/services/supplies	R	Enter appropriate five digits Current Procedural Terminology (CPT-4) or Health Care Financing Administration Common Procedural Coding System (HCPCS) code(s) that describe procedure/services/supplies. Use modifiers, if appropriate. Enter the appropriate Home Health Codes as follows: Skill Nursing Care: Y0701; Physical Therapy: Y0702; Speech Therapy: Y0703; Home Health Aide: Y0704; Occupational Therapy: Y0706
24e.	Diagnosis code	C	Enter International Classification of Diseases, 9th Revision (ICD-9) diagnosis code related to the service billed.
24f.	Charges	R	Enter the total charge(s) for procedure/services/supplies.
24g.	Days/units	R	Enter the number of times the procedure for which you are billing was performed.
24h.	EPSDT/family planning	C	If services were provided from a referral from Health Check (formally Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) enter "ET". *Note*: The Health Check program is only for those under 21 years of age. If services were for Family Planning purposes, enter "FP". This field is required for all Health Check/Family Planning procedure codes billed on claim. If neither applies, leave blank.
24i.	EMG	C	If the procedure code billed was the result of an emergency, enter "Y" for Yes.
24j.	COB	C	Must indicate and enter valid value for any other health insurance coverage. Valid values: *1* - No other health insurance *2* - Medicare *3* - Other insurance
24k.	Reserved for local use		
25.	Federal tax ID number	R	Enter Social Security number (SSN) or Employee Identification Number (EIN).
26.	Patient account number	C	Enter the patient's record number used internally by your office.
27.	Accepts assignment	R	Billing Medicaid indicates acceptance of assignment.
28.	Total charge	R	Enter the total of the charges listed for each line.
29.	Amount paid	C	Total amount paid by other insurance (third party).
30.	Balance Due	R	Enter submitted charge, less any third party payment received.
31.	Signature of physician or supplier and date	R	Provider must sign (or signature stamp) and provide degrees or credentials. Enter the current date. *Note:* Unsigned invoice/claims forms cannot be accepted for processing).
32.	Name and address of facility	R	Enter name and address where services were rendered (e.g., hospital, home, etc.).
33.	GRP number	C	Enter Medicaid group pay-to-provider number, if applicable.

APPENDIX J

Billing Manual

GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

Billing Manual

May 30, 2003

Table of Contents

Table of Figures

Table of Tables

1. Getting the Most from this Manual

This manual was created to help providers accurately complete and file Medicaid/PeachCare billing forms. This chapter includes an overview of the manual so you can quickly determine which section can answer your billing questions. You can use this section, along with the Table of Contents, to find exactly what you need without having to read the entire manual.

1.1 How this Manual Helps You

This manual helps you by offering billing instructions, sample Medicaid/PeachCare forms, and contact information for times when you need personal assistance.

1.2 What this Manual Won't Do

Some aspects of Medicaid/PeachCare billing are beyond the scope of this manual. Although it contains a robust selection of reference and how-to information, this Billing Manual:

- Does not contain actual Medicaid/PeachCare forms. Sample forms are included for your reference. The size of the original form is typically larger than the sample, which is not suitable for copying, completing, and submitting. However, you can photocopy, complete and submit the Provider Inquiry Form (DMA-520) and the GHP Request for Forms (DMA-292).

  To obtain actual Medicaid forms you can use:

  - **CMS 1500, UB-92, and ADA 1999 (version 2000) forms:** Contact your local print vendor or Internet health care forms vendor.

  - **GHP Request for Forms (DMA-292):** See page 52 for a copy of the DMA-292. You can also request a copy by calling (404) 298-1228 (Metro Atlanta) or (800) 766-4456 (toll free). Or, go to *www.ghp.georgia.gov* and click "Contact Us" in the upper right corner to send an e-mail request.

  - **All Georgia-specific forms:** Complete the DMA-292 form and mail to:

    GHP
    P.O. Box 5000
    McRae, GA 31055-5000

- Does not offer step-by-step instructions for using the web portal to complete claims. For specific web portal instructions, click the *Instructions* link from any web portal page.

- Does not explain how to create batch files from your office's practice management software, or describe specific steps for using electronic data interchange systems. Check with your software vendor for this information.

1.3 Topics Covered in this Manual

Each chapter in this manual addresses a specific billing topic.

Chapter Name and Page Number	What this Chapter Contains
Getting the Most from this Manual, page 1	• An overview of the manual so you can determine which section can answer your billing questions and contact information
Introduction, page 4	• A general introduction to GHP, Medicaid and PeachCare for Kids, and changes happening within the new system
Member Eligibility, page 7	• Sample notification letters, eligibility forms, and instructions for verifying eligibility
The Provider Inquiry Unit, page 21	• Details the services provided by the Provider Inquiry Unit and methods of contact
Paper Claim Forms, page 30	• Samples and descriptions of the CMS-1500, UB-92, and other forms
Miscellaneous Forms and Attachments, page 46	• Samples and descriptions of forms and affidavits for eligibility, referrals, requests, and more
Coordination of Benefits/Medicaid Secondary Payer, page 58	• Forms, instructions, and tips when filing claims that involve a secondary payer
Electronic Claims Submission, page 66	• Descriptions of methods and systems you can use for electronic filing, such as the web portal, dial-up systems, "host-to-host" telecommunication, and more
Remittance Advice, page 71	• Detailed descriptions of the Remittance Advice (RA) including claim totals, section totals, advice of professional services, and more
Financial Summary Page Adjustments, page 87	• Explanation of adjustments, refunds, completing the Adjustment Request Form, and more
Category of Services Numbers, page 93	• A list of the Categories of Service and their numbers
Resource Tools, page 95	• Additional resource tools not found elsewhere in this manual, such as billing assistance

1.4 When All Else Fails

You can contact the Customer Interaction Center (CIC) by dialing one of the following telephone numbers:

- (404) 298-1228 (Metro Atlanta)
- (800) 766-4456 (toll free)

When your call reaches the Interactive Voice Response System (IVRS), a greeting welcomes you to the provider voice response system. You are asked to press 1 for English or 2 for Spanish. (Selecting Spanish directs the caller to a bilingual Customer Service Representative (CSR). The IVRS is not available in Spanish for providers.)

You can press "0" to speak with a customer service representative. Be sure to have all claim documentation ready before you call.

2. Introduction

The Georgia Health Partnership (GHP) is the new third-party administrator for the Georgia Medicaid and PeachCare for Kids programs.

As Medicaid and PeachCare for Kids providers, you need to know the following key facts about this change and the benefits the Georgia Health Partnership brings to you.

GHP was selected to create and manage a state-of-the-art health care administration system for selected programs, including Georgia Medicaid and PeachCare for Kids. GHP consists of a prime contractor, Affiliated Computer Services, Inc. (ACS), a leading business process outsourcing firm, and other leading companies in technical and health care services.

2.1 Effective Date for Change in Third-Party Administrator

GHP assumed the duties of third-party administrator on April 1, 2003. Providers began submitting claims and other transactions to GHP as of that date.

NOTE:
GHP does *not* support the State Health Benefit Plan (SHBP) and the Board of Regents Health Plans (BORHP) benefit plans, as of April 1, 2003. Providers should continue to submit SHBP and BORHP claims to Blue Cross Blue Shield of Georgia. The Department of Community Health (DCH) can provide additional information regarding GHP support of SHBP and BORHP at a future time.

2.2 Medicaid, PeachCare, Funding, and Service Delivery in Georgia

Medicaid pays for medical care for low-income people who are age 65 and older, blind, disabled, children, pregnant, and parents with children. It is a federal entitlement program of medical assistance for the poor and is partially funded and administered by the state. The PeachCare for Kids Program is authorized by Title XXI of the Social Security Act and legislation passed during the 1998 session of the Georgia Assembly. PeachCare for Kids provides medical assistance to certain individuals with low to moderate income.

The State of Georgia and the federal government jointly fund Medicaid. In Georgia, the Georgia Department of Medical Assistance (DMA) had been the single state agency responsible for administering Georgia's Medicaid program. Effective July 1, 1999, DMA became the Division of Medical Assistance, an entity within the new DCH.

In Georgia, the Department of Community Health (DCH) Division of Medical Assistance (DMA) is the single state agency responsible for administering Georgia's Medicaid and PeachCare for Kids programs. A nine-member board appointed by the Governor presides over the DCH.

Service delivery is accomplished through a variety of relationships and agreements with private medical providers, state agencies, and private agencies, such as the:

- Georgia Medical Care Foundation (GMCF)

- Department of Human Resources (DHR)
- Social Security Administration (SSA)
- Outsourced Administrative Systems (OASYS)
- First Health Services (FHS)
- Health Calls Inc. Services (HCI)

2.3 New Options for Claims Submissions

GHP has implemented a new computer system for Medicaid and PeachCare for Kids claims processing, health care administration, and provider support. The new GHP computer system will benefit providers participating in the Medicaid and PeachCare for Kids programs in many ways, such as:

- More ways to submit electronic claims
- Quicker payments
- Online claim adjustments
- Electronic support for other health care transactions; GHP offers methods for providers to submit and inquire about:
    - Member eligibility
    - Referral, prior authorization, and pre-certification
    - Presumptive eligibility
    - Provider application
    - Claims
    - Many other transactions

For more general information about GHP, visit the DCH web page at *www.communityhealth.state.ga.us*.

2.4 Decisions You Need to Make

To ensure smooth and timely claims payment after April 1, 2003, providers and their billing support staff or billing vendors need to do the following:

- Select one or more of the claims submission methods available

  Providers may use one or more methods for submitting claims and receiving data from GHP. The chart on page 69 helps you understand your options.

- Make decisions regarding Health Insurance Portability and Accountability Act (HIPAA)

  From April 1, 2003 to October 16, 2003, the date when the HIPAA transaction standards go into effect, GHP will support both HIPAA file formats and certain other formats that are similar to those commonly used in the industry today. DCH encourages providers to adopt HIPAA formats as soon as possible after April 1, 2003. As of October 16, 2003, GHP will support only the HIPAA formats.

- Prepare to use national codes

  From April 1, 2003 through October 1, 2003, providers must continue to bill using local procedure codes. After October 1, 2003, GHP will require the national code sets mandated by HIPAA.

  Many local procedure codes will be replaced by national codes effective for dates of service on and after October 1, 2003. The local codes for which an appropriate national code could not be found will continue to be used until further notice.

  Other national code sets mandated by HIPAA such as ICD-9 (International Classification of Diseases, 9th Revision), POS (Place of Service), etc., must be used for all claims submitted to GHP with dates of service on and after October 1, 2003.

For more information about HIPAA, please visit *http://aspe.os.dhhs.gov/admnsimp/*.

2.5 What About My Office Staff?

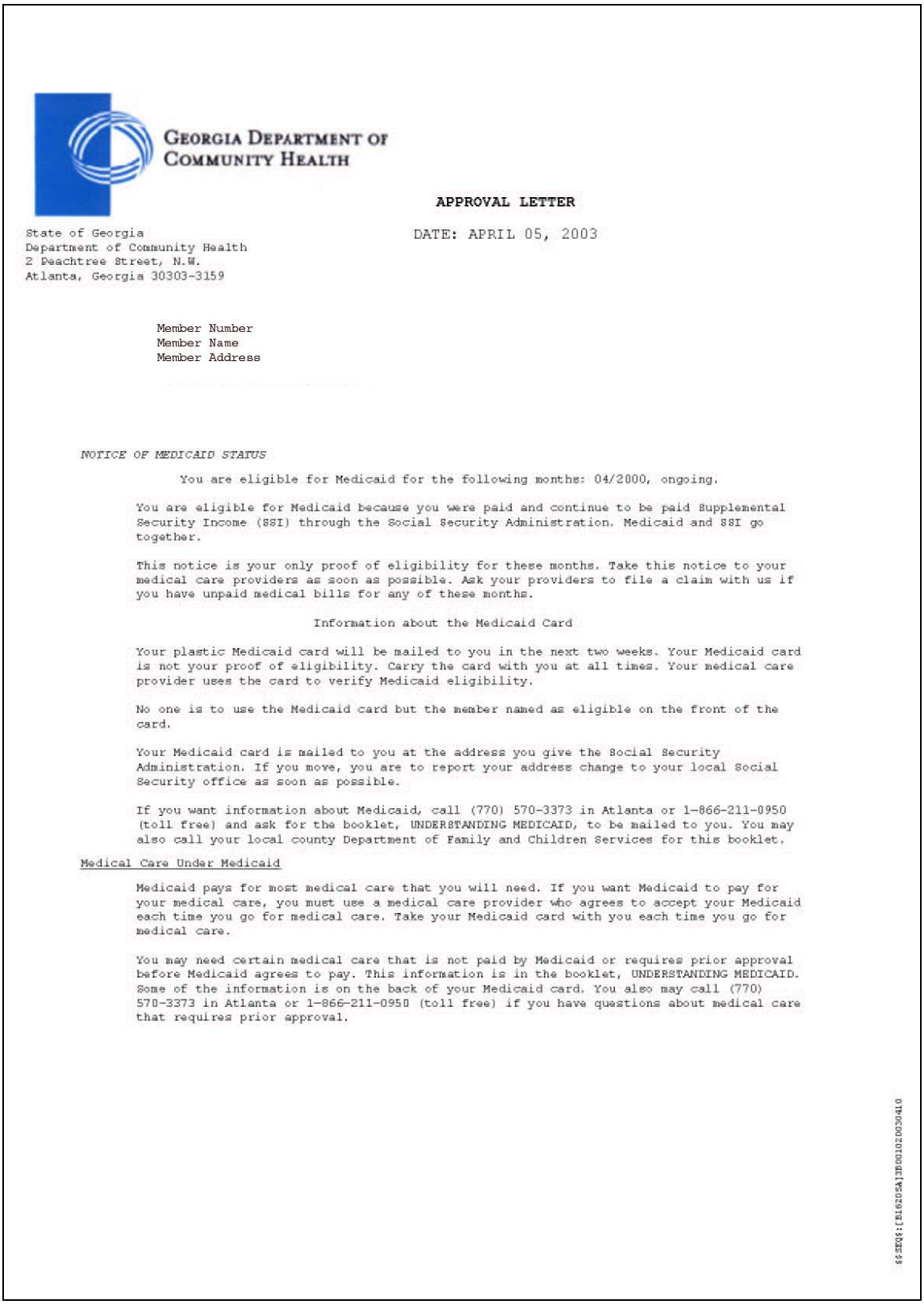
Provider office staffs may submit claims and other transactions on each provider's behalf. For providers who practice in more than one location, office staff members in each location (who utilize the web portal) are able to work on only the claims and other transactions pertinent to that location.

3. Member Eligibility

For detailed member eligibility information, please see the applicable DCH Provider Policy Manual.

3.1 Supplemental Security Income Notification Letter

This letter is issued by the DCH to the member. If the Date of Service (DOS) falls within the specified months, the letter serves to verify the member's eligibility. Use the name and Medicaid number designated in the letter on the claim, and attach a copy of the letter to the claim if submitting the claim via paper. If submitting the claim electronically, write the Transaction Control Number (TCN) of the claim on the paper documentation and mail it to P.O. Box 5000; McRae, GA 31055-5000.



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

APPROVAL LETTER

State of Georgia
Department of Community Health
2 Peachtree Street, N.W.
Atlanta, Georgia 30303-3159

DATE: APRIL 05, 2003

Member Number
Member Name
Member Address

NOTICE OF MEDICAID STATUS

You are eligible for Medicaid for the following months: 04/2000, ongoing.

You are eligible for Medicaid because you were paid and continue to be paid Supplemental Security Income (SSI) through the Social Security Administration. Medicaid and SSI go together.

This notice is your only proof of eligibility for these months. Take this notice to your medical care providers as soon as possible. Ask your providers to file a claim with us if you have unpaid medical bills for any of these months.

Information about the Medicaid Card

Your plastic Medicaid card will be mailed to you in the next two weeks. Your Medicaid card is not your proof of eligibility. Carry the card with you at all times. Your medical care provider uses the card to verify Medicaid eligibility.

No one is to use the Medicaid card but the member named as eligible on the front of the card.

Your Medicaid card is mailed to you at the address you give the Social Security Administration. If you move, you are to report your address change to your local Social Security office as soon as possible.

If you want information about Medicaid, call (770) 570-3373 in Atlanta or 1-866-211-0950 (toll free) and ask for the booklet, UNDERSTANDING MEDICAID, to be mailed to you. You may also call your local county Department of Family and Children Services for this booklet.

Medical Care Under Medicaid

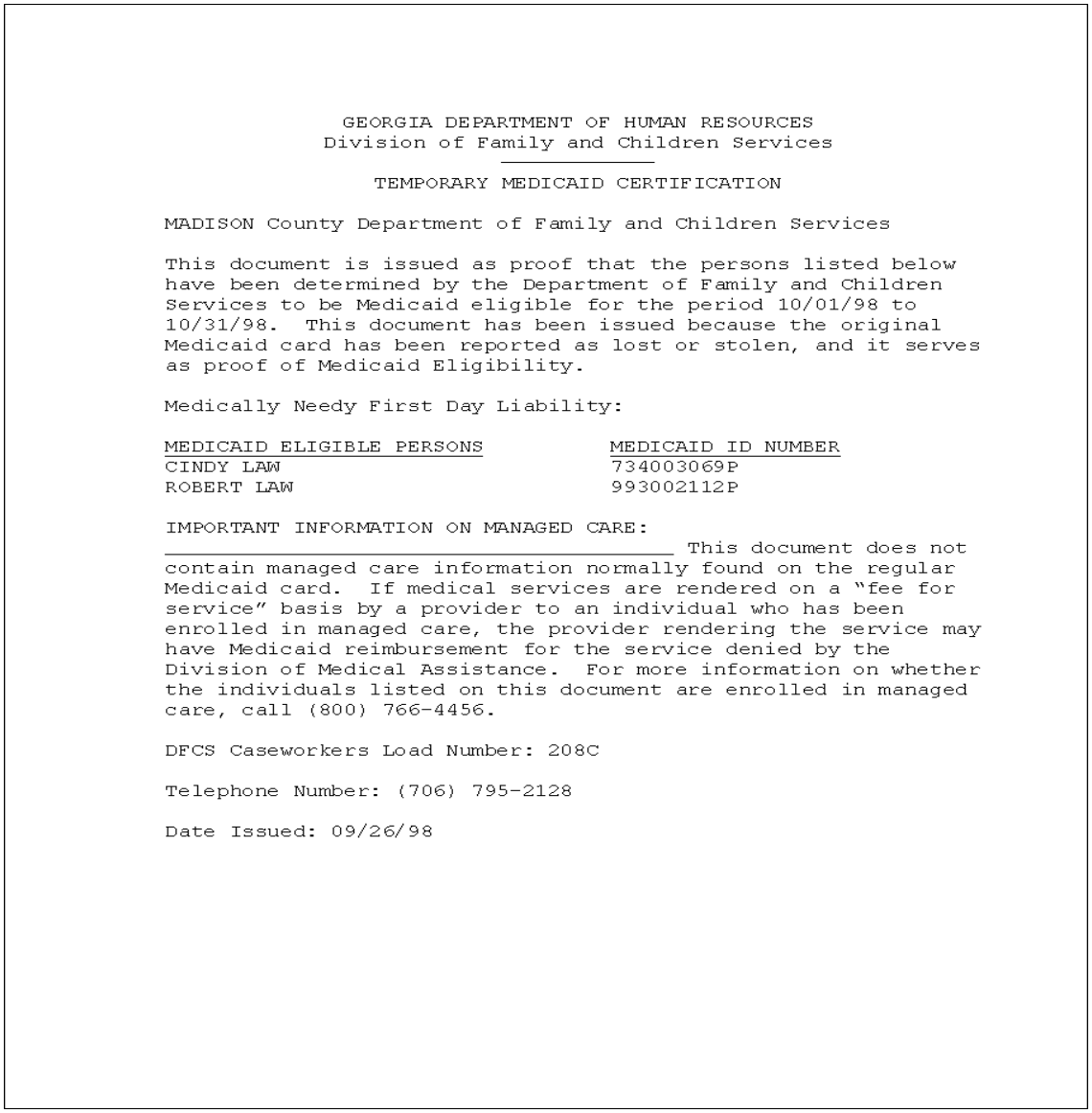
Medicaid pays for most medical care that you will need. If you want Medicaid to pay for your medical care, you must use a medical care provider who agrees to accept your Medicaid each time you go for medical care. Take your Medicaid card with you each time you go for medical care.

You may need certain medical care that is not paid by Medicaid or requires prior approval before Medicaid agrees to pay. This information is in the booklet, UNDERSTANDING MEDICAID. Some of the information is on the back of your Medicaid card. You also may call (770) 570-3373 in Atlanta or 1-866-211-0950 (toll free) if you have questions about medical care that requires prior approval.

Figure 3-1. Supplemental Security Income Notification Letter

3.2 Temporary Medicaid Certification (Form 962)

This letter is generated by the local DFCS office in response to a member's request for eligibility verification. Use the name and Medicaid number designated on the claim form, and keep a copy of the form for your records. The Medicaid ID number can be used to verify eligibility and obtain the MultiHealthNet (MHN) ID number, which will be used for claims payment. This information will also appear on your Remittance Advice. If a copy of this card must be submitted with a claim, you may file the claim electronically; then, write the Transaction Control Number (TCN) across the top of this form and fax it to the Customer Interaction Center (CIC) at 1-866-483-1044.



GEORGIA DEPARTMENT OF HUMAN RESOURCES
Division of Family and Children Services

TEMPORARY MEDICAID CERTIFICATION

MADISON County Department of Family and Children Services

This document is issued as proof that the persons listed below have been determined by the Department of Family and Children Services to be Medicaid eligible for the period 10/01/98 to 10/31/98. This document has been issued because the original Medicaid card has been reported as lost or stolen, and it serves as proof of Medicaid Eligibility.

Medically Needy First Day Liability:

MEDICAID ELIGIBLE PERSONS	MEDICAID ID NUMBER
CINDY LAW	734003069P
ROBERT LAW	993002112P

IMPORTANT INFORMATION ON MANAGED CARE:
This document does not contain managed care information normally found on the regular Medicaid card. If medical services are rendered on a "fee for service" basis by a provider to an individual who has been enrolled in managed care, the provider rendering the service may have Medicaid reimbursement for the service denied by the Division of Medical Assistance. For more information on whether the individuals listed on this document are enrolled in managed care, call (800) 766-4456.

DFCS Caseworkers Load Number: 208C

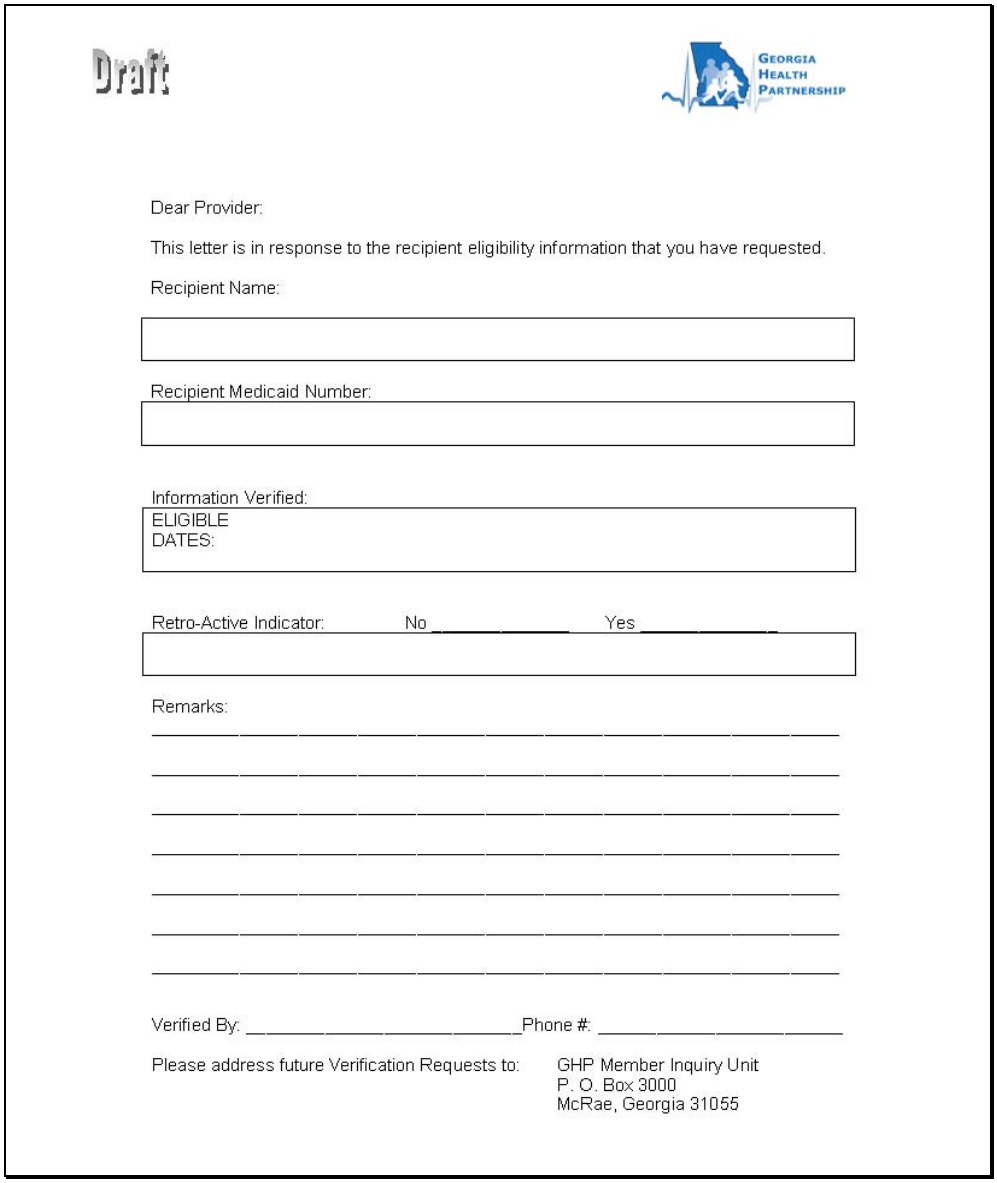
Telephone Number: (706) 795-2128

Date Issued: 09/26/98

Figure 3-2. Temporary Medicaid Certification (Form 962)

3.3 DMA-304 Form and Letter

DMA-304 Form (Figure 3-3) and its companion letter (Figure 3-4) are issued by DCH to the member. If the date of service falls within the specified months, the letter serves to verify the member's eligibility. Use the name and Medicaid number designated in the letter on the claim, and keep a copy of the form for your records. The Medicaid ID number can be used to verify eligibility and obtain the MultiHealthNet (MHN) ID number, which will be used for claims payment. This information will also appear on your Remittance Advice. If a copy of this card must be submitted with a claim, you may file the claim electronically; then, write the Transaction Control Number (TCN) across the top of this form and fax it to the Customer Interaction Center (CIC) at 1-866-483-1044. You may also e-mail us using the "Contact Us" feature on the web portal.



Draft

GEORGIA HEALTH PARTNERSHIP

Dear Provider:

This letter is in response to the recipient eligibility information that you have requested.

Recipient Name:

Recipient Medicaid Number:

Information Verified:
ELIGIBLE
DATES:

Retro-Active Indicator: No _____ Yes _____

Remarks:

Verified By: _____Phone #: _____

Please address future Verification Requests to: GHP Member Inquiry Unit
P. O. Box 3000
McRae, Georgia 31055

Figure 3-3. DMA-304 Form

_____

_____

_____

Dear _____:

This letter is in response to the request the Georgia Health Partnership Member Inquiry Unit received from you regarding Medicaid Eligibility.

The enclosed DMA-304 form indicating the dates of your eligibility can be submitted to the provider (doctor, hospital, etc.) as proof of your eligibility. Medicaid will pay claims up to six months from the date of service or six months from the retroactive date. Claims can be filed up to one year from the date of service when a provider has not been informed of a recipient's Medicaid eligibility. These claims must have an Affidavit of Unknown Medicaid Eligibility attached to them. Providers can find this form in their Policy and Procedures Manual.

Please contact us by phone at 770-570-3373 or toll-free at 1-866-211-0950 or in writing at P. O. Box 3000, McRae, Georgia 31055, if you have any question regarding the above information.

Sincerely,

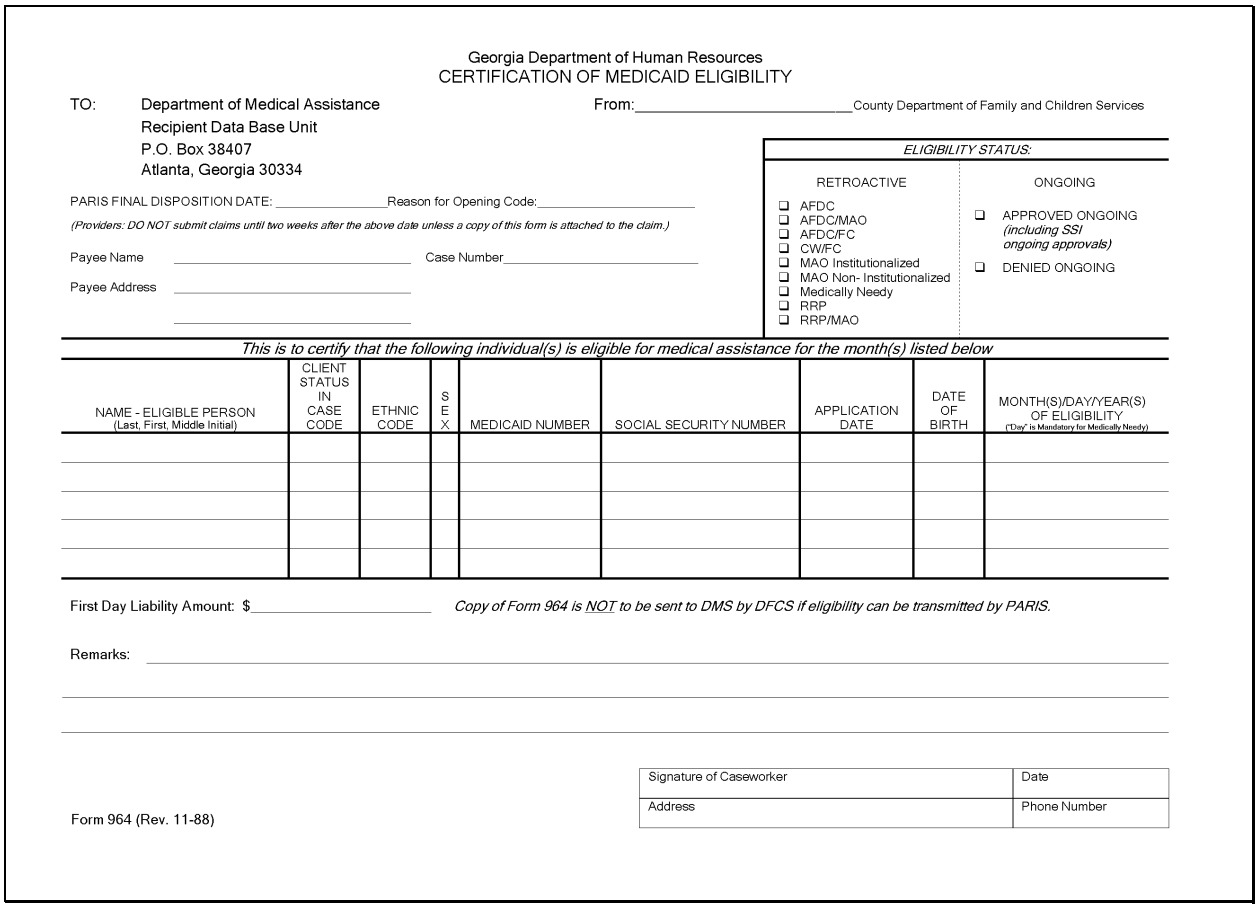
The Member Inquiry Unit at
The Georgia Health Partnership Project
770-570-3373

Figure 3-4. Companion Letter to DMA-304 Form

3.4 Certification of Retroactive Medicaid Eligibility (Form 964)

Two styles of retroactive certification forms are issued by the county DFCS to members. One style of the retroactive certification form is completed by hand. (See Figure 3-4.) The other type is computer generated. (See Figure 3-5.) A member may present one of the two forms to you as verification of eligibility for the month(s) shown on the form. Use the name and Medicaid number from the retroactive certification form when filing a claim for services provided in the Month(s)/Day/Year(s) of Eligibility field shown on the retroactive certification form. When filing your claim, keep a copy of the form for your records. The Medicaid ID number can be used to verify eligibility and obtain the MHN ID number, which will be used for claims payment. This information will also appear on your Remittance Advice. If a copy of this card must be submitted with a claim, you may file the claim electronically; then, write the TCN across the top of this form and fax it to the CIC at 1 (866) 483-1044.

The following form can be issued when the member needs immediate care or is applying onsite for Medicaid.



Georgia Department of Human Resources
CERTIFICATION OF MEDICAID ELIGIBILITY

TO: Department of Medical Assistance
Recipient Data Base Unit
P.O. Box 38407
Atlanta, Georgia 30334

From:_____County Department of Family and Children Services

PARIS FINAL DISPOSITION DATE: _____Reason for Opening Code:_____

(Providers: DO NOT submit claims until two weeks after the above date unless a copy of this form is attached to the claim.)

Payee Name _____ Case Number_____

Payee Address _____

_____

ELIGIBILITY STATUS:

RETROACTIVE	ONGOING
❑ AFDC ❑ AFDC/MAO ❑ AFDC/FC ❑ CW/FC ❑ MAO Institutionalized ❑ MAO Non- Institutionalized ❑ Medically Needy ❑ RRP ❑ RRP/MAO	❑ APPROVED ONGOING *(including SSI ongoing approvals)* ❑ DENIED ONGOING

This is to certify that the following individual(s) is eligible for medical assistance for the month(s) listed below

NAME - ELIGIBLE PERSON (Last, First, Middle Initial)	CLIENT STATUS IN CASE CODE	ETHNIC CODE	SEX	MEDICAID NUMBER	SOCIAL SECURITY NUMBER	APPLICATION DATE	DATE OF BIRTH	MONTH(S)/DAY/YEAR(S) OF ELIGIBILITY ("Day" is Mandatory for Medically Needy)

First Day Liability Amount: $_____ *Copy of Form 964 is NOT to be sent to DMS by DFCS if eligibility can be transmitted by PARIS.*

Remarks: _____

Signature of Caseworker	Date
Address	Phone Number

Form 964 (Rev. 11-88)

Figure 3-5. Certification of Retroactive Medicaid Eligibility (Form 964)

NOTE:
Members who are eligible for benefits only as Qualified Medicare Beneficiaries (QMBs) are not eligible for outpatient pharmacy benefits.

3.5 Certification of Retroactive Medicaid Eligibility (Computer Generated)

Following is an example of the computer generated retroactive certification form. This form is issued by the county DFCS and can be used retroactively.

```
 Client Number: 734003069        01-000041          PAGE 5
 ____________________________________________________________

0062 - CERTIFICATION OF MEDICAID ELIGIBILITY

MADISON County Department of Family and Children Services

FINAL DISPOSITION DATE:  10 01 98

(Providers: DO NOT submit claims until two weeks after the above
date unless a copy of this form is attached to the claim.)

 Payee Name: LAW  , CINDY                    AU  ID:  188501907

Payee Address:    123 MAIN ST
                            DANIELSVILLE GA  30633-4207

This is to certify that the following individual (s) is eligible
for Medical Assistance (Medicaid) for the month (s) listed below:

LIST OF ELIGIBLE PERSONS:
    ..... Name _______

 Last       First    M     SEX      MA ID           SSN             DOB
LAW         CINDY           F    734003069P     789-78-9489      08 17 61
                    Eligible 10 01 98 thru 10 31 98
                    Eligible 09 01 98 thru 09-30 98
LAW         ROBERT        M     993002112P     456-78-9747      08 16 95
                    Eligible 10/01/98 thru 10 31 98
                    Eligible 09 01 98 thru 09 30 98
```

Figure 3-6. Certification of Retroactive Medicaid Eligibility (Computer Generated)

3.6 Certification of Supplemental Security Income Eligibility

The Social Security Administration issues this letter. If the Date of Service is included within the specified month, this letter serves as verification of the member's eligibility. Use the name and Medicaid number designated on the letter on the claim, and keep a copy of the form for your records. The Medicaid ID number can be used to verify eligibility and obtain the MHN ID number, which will be used for claims payment. This information will also appear on your Remittance Advice. If a copy of this card must be submitted with a claim, you may file the claim electronically; then, write the TCN across the top of this form and fax it to the Customer Interaction Center (CIC) at 1 (866) 483-1044.

CERTIFICATION OF SSI ELIGIBILITY

MEMORANDUM

TO: _____ County Office
Department of Family and Children's Services

FM: Social Security Adm.
Bx 938
Gainesville, GA 30503

RE: Verification of SSI Eligibility for Establishing Medical Assistance on an Emergency Basis

The individual identified below is in emergency need of medical assistance and is eligible for Supplemental Security Income (SSI) cash payments. Please use the verification provided below to establish medical assistance.

Name of Eligible Individual: _____

Address: _____

Social Security No.: _____ Date o f Birth: _____ Sex: _____

Social Security Claim No. (if different): _____

Aged _____ Blind _____ Disabled _____ Date of Application: _____

This individual is SSI eligible and receiving SSI payments (effective date) _____ through the end of _____.

Are there any months of ineligibility for SSI between the two dates given above?
Yes ___ No ___

If not, please identify each month/year the individual was not residing in Georgia.
_____

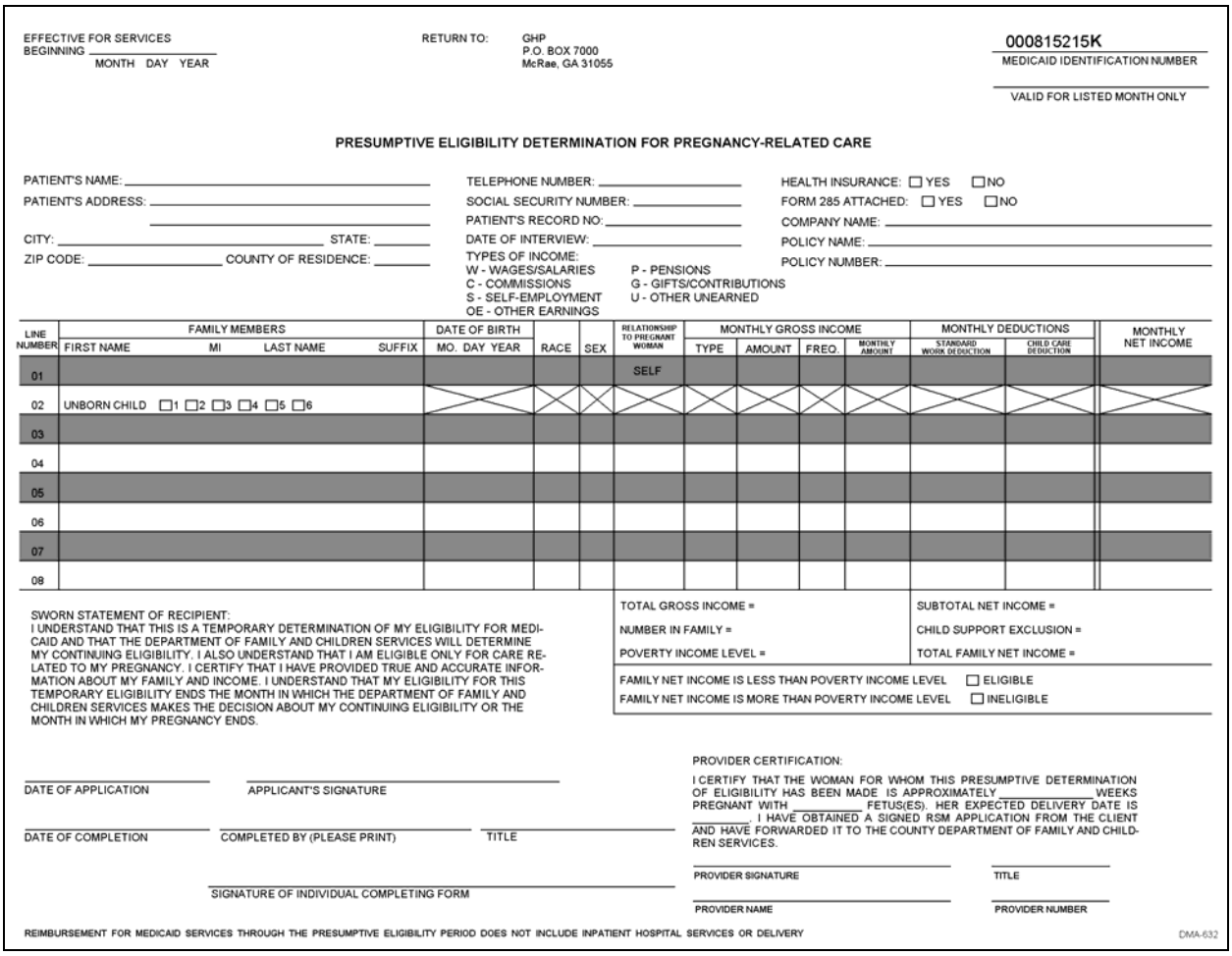
Has this individual either refused to assign to the State his/here rights to third party resources or agreed to assign to the State these right but failed to cooperate in providing information about his/her third party resources?
Yes ___ No ___

Prepared by: _____ Title: _____

Figure 3-7. Certification of Supplemental Security Income Eligibility Letter

3.7 Presumptive Eligibility for Pregnant Women (DMA-632)

The qualified provider issues the DMA 632 to the presumptively eligible member. This worksheet serves as the first month's Medicaid certification. There is also a computer-generated version of form DMA-632 that is produced via the web portal (See Figure 3.9). The computer-generated form (DMA-632) also serves as the first month's Medicaid certification for the presumptively eligible member.



EFFECTIVE FOR SERVICES BEGINNING _____ MONTH DAY YEAR

RETURN TO: GHP, P.O. BOX 7000, McRae, GA 31055

000815215K
MEDICAID IDENTIFICATION NUMBER

VALID FOR LISTED MONTH ONLY

PRESUMPTIVE ELIGIBILITY DETERMINATION FOR PREGNANCY-RELATED CARE

PATIENT'S NAME: _____ TELEPHONE NUMBER: _____ HEALTH INSURANCE: ☐ YES ☐ NO
PATIENT'S ADDRESS: _____ SOCIAL SECURITY NUMBER: _____ FORM 285 ATTACHED: ☐ YES ☐ NO
_____ PATIENT'S RECORD NO: _____ COMPANY NAME: _____
CITY: _____ STATE: _____ DATE OF INTERVIEW: _____ POLICY NAME: _____
ZIP CODE: _____ COUNTY OF RESIDENCE: _____ POLICY NUMBER: _____

TYPES OF INCOME:
W - WAGES/SALARIES P - PENSIONS
C - COMMISSIONS G - GIFTS/CONTRIBUTIONS
S - SELF-EMPLOYMENT U - OTHER UNEARNED
OE - OTHER EARNINGS

LINE NUMBER	FAMILY MEMBERS: FIRST NAME	MI	LAST NAME	SUFFIX	DATE OF BIRTH: MO. DAY YEAR	RACE	SEX	RELATIONSHIP TO PREGNANT WOMAN	MONTHLY GROSS INCOME: TYPE	AMOUNT	FREQ.	MONTHLY AMOUNT	MONTHLY DEDUCTIONS: STANDARD WORK DEDUCTION	CHILD CARE DEDUCTION	MONTHLY NET INCOME
01								SELF							
02	UNBORN CHILD ☐1 ☐2 ☐3 ☐4 ☐5 ☐6														
03															
04															
05															
06															
07															
08															

SWORN STATEMENT OF RECIPIENT:
I UNDERSTAND THAT THIS IS A TEMPORARY DETERMINATION OF MY ELIGIBILITY FOR MEDICAID AND THAT THE DEPARTMENT OF FAMILY AND CHILDREN SERVICES WILL DETERMINE MY CONTINUING ELIGIBILITY. I ALSO UNDERSTAND THAT I AM ELIGIBLE ONLY FOR CARE RELATED TO MY PREGNANCY. I CERTIFY THAT I HAVE PROVIDED TRUE AND ACCURATE INFORMATION ABOUT MY FAMILY AND INCOME. I UNDERSTAND THAT MY ELIGIBILITY FOR THIS TEMPORARY ELIGIBILITY ENDS THE MONTH IN WHICH THE DEPARTMENT OF FAMILY AND CHILDREN SERVICES MAKES THE DECISION ABOUT MY CONTINUING ELIGIBILITY OR THE MONTH IN WHICH MY PREGNANCY ENDS.

TOTAL GROSS INCOME = SUBTOTAL NET INCOME =
NUMBER IN FAMILY = CHILD SUPPORT EXCLUSION =
POVERTY INCOME LEVEL = TOTAL FAMILY NET INCOME =

FAMILY NET INCOME IS LESS THAN POVERTY INCOME LEVEL ☐ ELIGIBLE
FAMILY NET INCOME IS MORE THAN POVERTY INCOME LEVEL ☐ INELIGIBLE

_____ DATE OF APPLICATION _____ APPLICANT'S SIGNATURE

_____ DATE OF COMPLETION _____ COMPLETED BY (PLEASE PRINT) _____ TITLE

_____ SIGNATURE OF INDIVIDUAL COMPLETING FORM

PROVIDER CERTIFICATION:
I CERTIFY THAT THE WOMAN FOR WHOM THIS PRESUMPTIVE DETERMINATION OF ELIGIBILITY HAS BEEN MADE IS APPROXIMATELY _____ WEEKS PREGNANT WITH _____ FETUS(ES). HER EXPECTED DELIVERY DATE IS _____. I HAVE OBTAINED A SIGNED RSM APPLICATION FROM THE CLIENT AND HAVE FORWARDED IT TO THE COUNTY DEPARTMENT OF FAMILY AND CHILDREN SERVICES.

_____ PROVIDER SIGNATURE _____ TITLE

_____ PROVIDER NAME _____ PROVIDER NUMBER

REIMBURSEMENT FOR MEDICAID SERVICES THROUGH THE PRESUMPTIVE ELIGIBILITY PERIOD DOES NOT INCLUDE INPATIENT HOSPITAL SERVICES OR DELIVERY

DMA-632

Figure 3-8. Presumptive Eligibility for Pregnant Women Worksheet (DMA-632)

NOTE:

Presumptive eligibility covers all Medicaid services except inpatient hospital services and delivery procedures.

The member receives the green copy of the worksheet.

The following information (DMA-632) serves as the member's temporary identification card and may be used as confirmation of presumptive eligibility for the Medicaid program (as of the indicated date). You should print this page and give it to the member. A member can use the computer-generated page/information until the permanent member identification card arrives.

The permanent member identification card is mailed to the address displayed on the computer-generated page.

NOTE:
Inpatient hospital or delivery services are not covered by this eligibility.

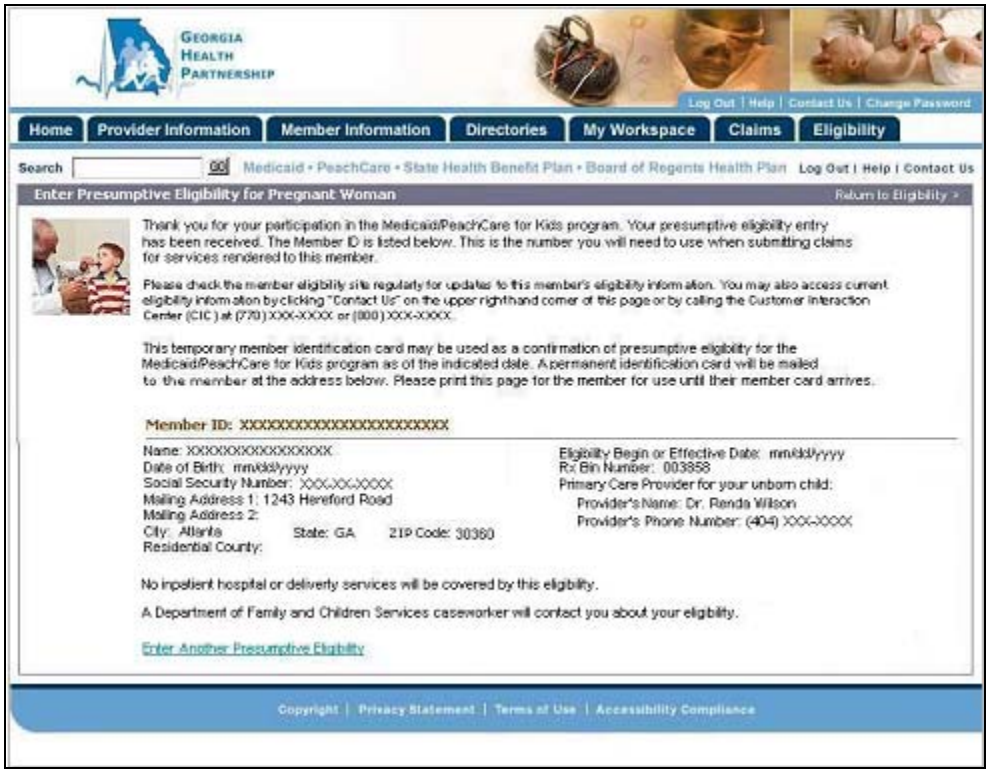


Figure 3-9. Presumptive Eligibility for Pregnant Woman (Computer Generated)

3.8 Presumptive Eligibility for Women's Health Medicaid Worksheet (DMA-632W)

The Women's Health Medicaid program is for women who have been through special screening and have a diagnosis of breast or cervical cancer. The qualified provider issues the DMA-632W worksheet to the presumptively eligible member. This worksheet serves as the first month's Medicaid certification. There is also a computer generated form DMA 632W that is produced via the web portal. The computer generated form DMA 632W also serves as the first month's Medicaid certification to the presumptively eligible member. (See figure 3.11 for an example of the computer generated form.)

EFFECTIVE FOR SERVICES BEGINNING _____ MONTH DAY YEAR

175 XXXXXX1D00
MEDICAID IDENTIFICATION NUMBER

VALID FOR LISTED MONTH ONLY

ELIGIBILITY DETERMINATION FOR WOMEN'S HEALTH MEDICAID PROGRAM

PATIENT'S NAME: _____
PATIENT'S ADDRESS: _____
_____
CITY: _____ STATE: _____
ZIP CODE: _____ COUNTY: _____

TELEPHONE NUMBER: DAY: _____
EVENING: _____
SOCIAL SECURITY NO.: _____
PATIENT'S RECORD NO.: _____
DATE OF INTERVIEW: _____

DO YOU HAVE HEALTH INSURANCE THAT COVERS THE COST OF CANCER TREATMENT? ☐YES ☐NO

FORM 285 ATTACHED: ☐YES ☐NO

LINE NUMBER	APPLICANT'S NAME			DATE OF BIRTH			RACE (OPTIONAL)	SEX
	FIRST NAME	M.I.	LAST NAME	MO	DAY	YR		
01								

SWORN STATEMENT OF APPLICANT

I UNDERSTAND THAT THIS IS A TEMPORARY DETERMINATION OF MY ELIGIBILITY FOR MEDICAID AND THAT A RIGHT FROM THE START MEDICAID (RSM)/DEPARTMENT OF FAMILY AND CHILDREN SERVICES WORKER WILL DETERMINE MY CONTINUING ELIGIBILITY. I UNDERSTAND THAT I MUST GIVE TRUE AND CORRECT INFORMATION ABOUT MYSELF AND MY SITUATION. I UNDERSTAND THAT I MUST REPORT ANY CHANGES IN MY CIRCUMSTANCES WITHIN TEN (10) DAYS OF BECOMING AWARE OF THE CHANGE. I UNDERSTAND THAT WHEN THE FINAL ELIGIBILITY DETERMINATION IS COMPLETED, I HAVE THE RIGHT TO A FAIR HEARING IF I DO NOT LIKE THE DECISION ON MY CASE. I CAN REQUEST A FAIR HEARING BY CONTACTING THE RIGHT FROM THE START MEDICAID PROJECT AT 1-800-809-7276.

I CERTIFY THAT THE INFORMATION I HAVE PROVIDED IS CORRECT. I HAVE READ (OR HAD READ TO ME) AND UNDERSTAND THE INFORMATION ON THIS FORM.

DATE OF APPLICATION _____ APPLICANT'S SIGNATURE _____

DATE OF COMPLETION _____ COMPLETED BY (PLEASE PRINT) _____ TITLE _____

SIGNATURE OF INDIVIDUAL COMPLETING FORM _____

PROVIDER CERTIFICATION:

I CERTIFY THAT THE WOMAN FOR WHOM THIS DETERMINATION IS MADE WAS SCREENED IN ACCORDANCE WITH THE REQUIREMENTS OF PUBLIC LAW 106-354. ON _____, HER DIAGNOSIS MET THE REQUIREMENTS FOR THE BCC MEDICAID COVERAGE IN GEORGIA. A COPY OF THIS APPLICATION HAS BEEN FORWARDED TO THE APPROPRIATE DFACS/RSM OFFICE FOR A DETERMINATION OF ONGOING ELIGIBILITY.

PROVIDER SIGNATURE _____ TITLE _____

PROVIDER NAME _____ PROVIDER NUMBER _____

PROVIDER TELEPHONE NUMBER _____

DMA-632-W

Figure 3-10. Presumptive Eligibility for Women's Health Medicaid Worksheet (DMA-632W)

The DMA-632W (computer-generated) serves as the member's temporary identification card and may be used as confirmation of presumptive eligibility for the Medicaid program (as of the indicated date). You should print this page and give it to the member. The member can use the computer-generated page/information until the permanent member identification card arrives.

The permanent member identification card is mailed to the address displayed on the computer-generated page.

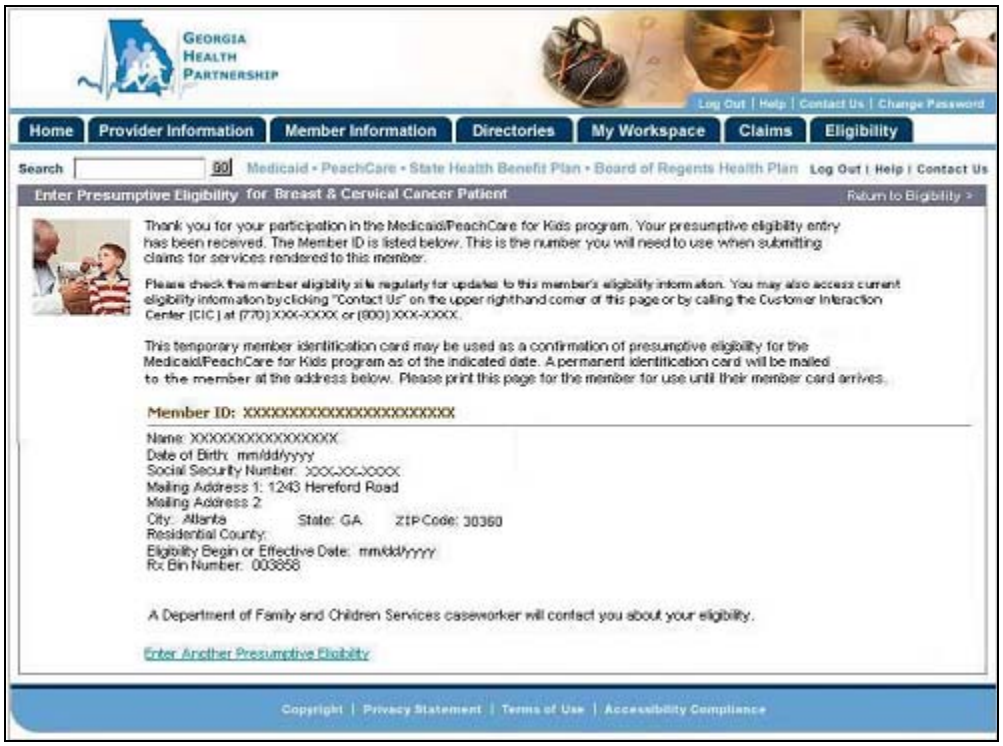
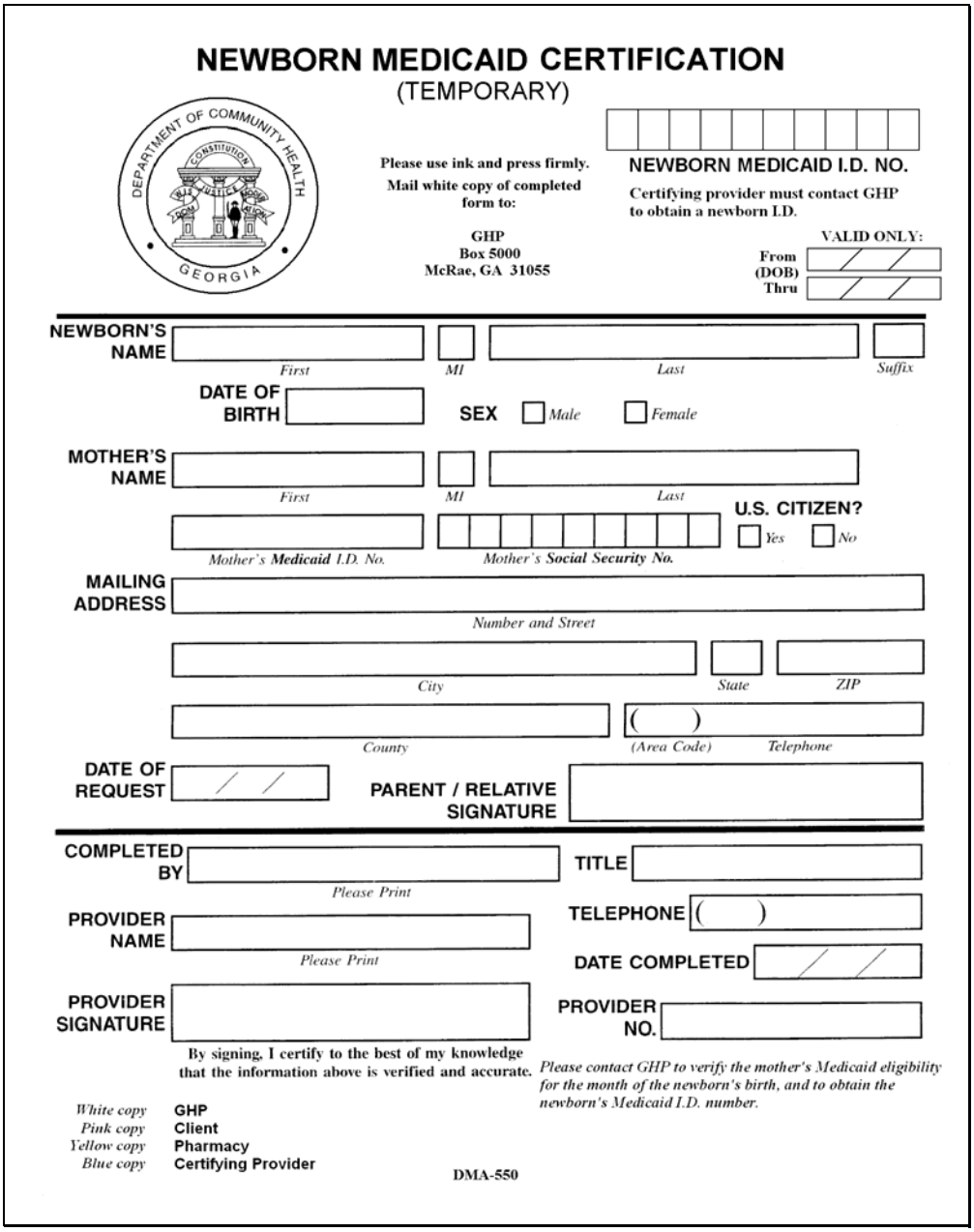


Figure 3-11. Presumptive Eligibility for Women's Health Medicaid (Computer Generated)

3.9 Newborn Eligibility (DMA-550)

The qualified provider issues the DMA-550 worksheet to a newborn's mother. This worksheet serves as the first month's Medicaid certification. There is also a computer-generated DMA-550 worksheet that is produced via the web portal. (See Figure 3-13 for an example of the computer generated form.)



NEWBORN MEDICAID CERTIFICATION
(TEMPORARY)

Please use ink and press firmly.
Mail white copy of completed form to:

GHP
Box 5000
McRae, GA 31055

NEWBORN MEDICAID I.D. NO.
Certifying provider must contact GHP to obtain a newborn I.D.

VALID ONLY:
From (DOB)
Thru

NEWBORN'S NAME — First | MI | Last | Suffix
DATE OF BIRTH
SEX ☐ Male ☐ Female

MOTHER'S NAME — First | MI | Last
Mother's **Medicaid** I.D. No.
Mother's **Social Security** No.
U.S. CITIZEN? ☐ Yes ☐ No

MAILING ADDRESS — Number and Street
City | State | ZIP
County | (Area Code) Telephone

DATE OF REQUEST
PARENT / RELATIVE SIGNATURE

COMPLETED BY — Please Print
TITLE
PROVIDER NAME — Please Print
TELEPHONE ( )
DATE COMPLETED
PROVIDER SIGNATURE
PROVIDER NO.

By signing, I certify to the best of my knowledge that the information above is verified and accurate.

Please contact GHP to verify the mother's Medicaid eligibility for the month of the newborn's birth, and to obtain the newborn's Medicaid I.D. number.

White copy GHP
Pink copy Client
Yellow copy Pharmacy
Blue copy Certifying Provider

DMA-550

Figure 3-12. Newborn Eligibility Worksheet (DMA-550)

The following information (DMA-550W) serves as the member's temporary identification card and may be used as confirmation of presumptive eligibility for the Medicaid program (as of the indicated date). You should print this page and give it to the member.

The member can use the computer-generated page/information until the permanent member identification card arrives. The permanent member identification card is mailed to the address displayed on the member's temporary identification (i.e., the computer-generated form).

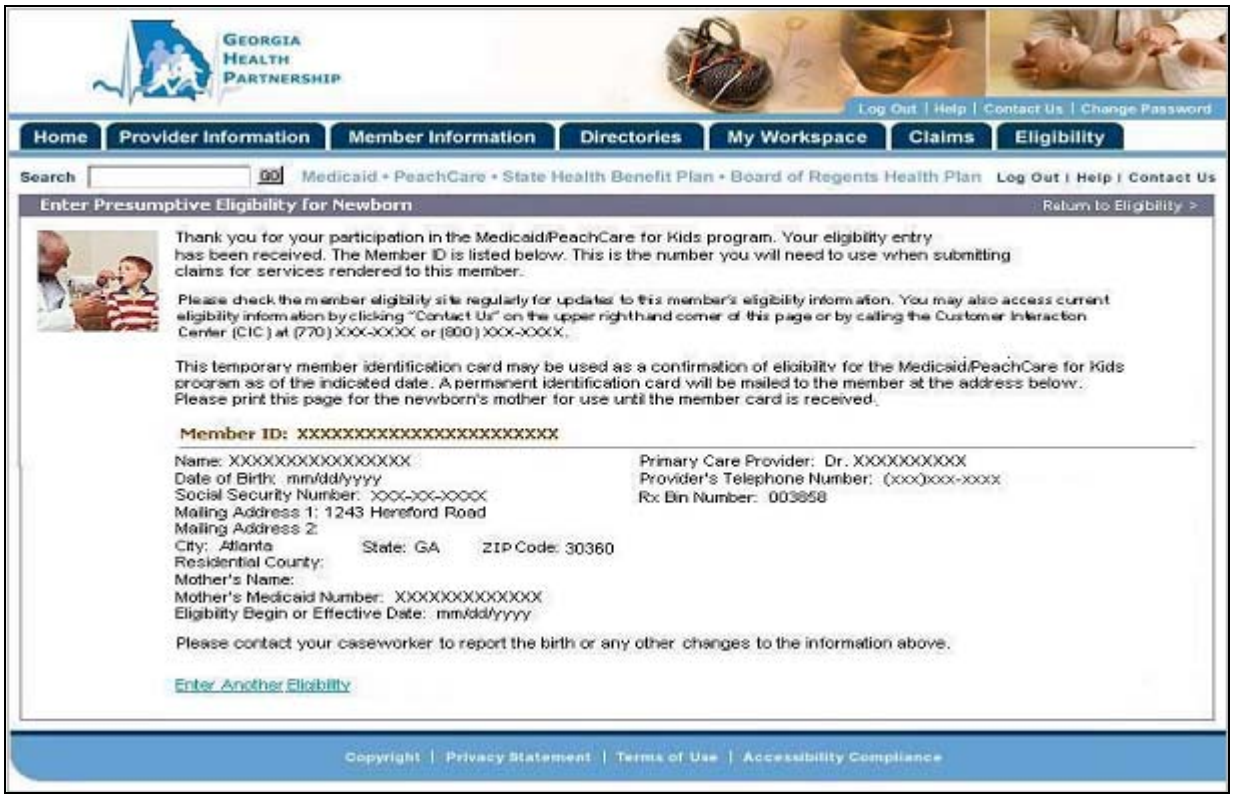


Figure 3-13. Newborn Eligibility (Computer Generated)

4. The Provider Inquiry Unit

The GHP offers providers easy access to current Medicaid and PeachCare for Kids information. The Provider Inquiry Unit responds to inquiries regarding:

- Billing procedures
- Claims payment/status
- Electronic claim submission
- Georgia Better Health Care referrals
- Member eligibility
- Member liability
- Program benefits
- Provider enrollment
- Service limitations
- Web portal functionality
- Prior authorizations and pre-certifications

Providers can contact the GHP by using any of these convenient methods:

- Phone: Interactive Voice Response System (IVRS) and customer services representatives
- The "*Contact Us"* function on the web portal
- The U.S. mail

NOTE:
The Electronic Data Interchange (EDI) contact number is (866) 211-0950.

4.1 Interactive Voice Response System

The Provider IVRS is the automated phone system serving GHP providers. The IVRS handles automated functions.

You can reach the IVRS by dialing one of the following numbers from any touch-tone telephone:

- (404) 298-1228 (Metro Atlanta)
- (800) 766-4456 (toll free).

When your call reaches the IVRS, a greeting welcomes you to the provider Interactive Voice Response System. You are asked to press 1 for English or 2 for Spanish. (Pressing 2 transfers you to a bilingual customer service representative. The IVRS is not available in Spanish for providers.) You can press 0 to speak with a customer service representative.

The IVRS also provides additional instructions for entering provider identification information.

NOTE:
A separate IVRS is also available for members of the Georgia Medicaid and PeachCare for Kids programs. The member IVRS provides members with automated responses to inquiries via a touch-tone telephone (770) 570-3373 Metro Atlanta or (800) 211-0950 toll free.

Please refer to your Georgia Medicaid and PeachCare for Kids members to the member IVRS for assistance.

4.2 Interactive Voice Response System Options

The Provider IVRS system options are explained below:

4.2.1 Option 1, Member Eligibility Inquiries

Option 1 provides you with specific information regarding the member's eligibility. This information can include:

- Eligibility verification
- Service restrictions
- Member lock-in information (such as GBHC or SOURCE, including phone number of the provider)
- Medicare coverage
- Coordination of Benefits (COB) coverage information

4.2.2 Option 2, Claim Status Inquiries

Option 2 provides you with information regarding:

- The status of the claim
- Date the claim was processed
- Exception codes posting to the claim (if applicable). You can also get additional information on numeric exception codes by visiting the GHP Web Portal (*http://www.ghp.georgia.gov*).

4.2.3 Option 3, Last Payment/Electronic Funds Transfer Status

Option 3 provides you with information regarding:

- Payment amount
- Payment date
- Payment number

4.2.4 Option 4, Last 3 Payment/Electronic Funds Transfer Status

Option 4 provides you with information regarding:

- Payment amount
- Payment date
- Payment number

4.2.5 Option 5, Service Limits

Option 5 provides you with information regarding service limits exhausted by the member (based on claims paid) as of the current date.

4.2.6 Option 6, Prior Authorization Inquiries

Option 6 provides you with information regarding the status of the prior authorization. This information includes procedure codes and units (or dollar amount) remaining. If you request a new prior authorization, you can press 1 to transfer to GMCF.

4.2.7 Option 7, Transfer to Express Scripts, Inc.

Option 7 allows you to transfer to ESI for inquiries regarding pharmacy claims.

4.2.8 Option 8, Transfer to Georgia Medical Care Foundation

Option 8 allows you to transfer to GMCF for information regarding the Nurse Aide Program.

4.2.9 Option 9, Transfer to PeachCare for Kids

Option 9 allows you to transfer to Dental Health Administrative and Consulting Services (DHACS). DHACS handles all calls for the PeachCare for Kids program.

4.2.10 Option 10, Referral Process

Option 10 allows you to check the status of an existing referral or create a new referral record. To create a new referral record, you need the provider reference identification number for the provider to whom the member is being referred. This information can be obtained by using the Find a GBHC Provider link on the web portal.

4.3 Entering a Letter into the Interactive Voice Response System

To enter a letter (e.g., a b, c) into the IVRS, you must enter the following:

1. Press the star (*****) key.
2. Press the key with the letter you wish to enter.
3. Press the key number **1**, **2**, or **3** to indicate the position of the letter on that key.

For example, to enter the letter **N**, press these keys in the order indicated:

1. Star (*****).
2. Key number **6** (because N is on the 6 key).
3. Key number **2** (because N is the second letter on the 6 key).

4.4 Entering the Letters Q and Z

Entering the letters Q and Z requires a slightly different approach:

- For the letter "**Q**", press star-zero-one.
- For the letter "**Z**", press star-zero-two.

Table 4-1. Conversion Table for Alpha to Numeric Characters

A = *21	F = *33	K = *52	P = *71	U = *82
B = *22	G = *41	L = *53	Q = *01	V = *83
C = *23	H = *42	M = *61	R = *72	W = *91
D = *31	I = *43	N = *62	S = *73	X = *92
E = *32	J = *51	O = *63	T = *81	Y = *93
				Z = *02

4.5 The "Contact Us" Function on the Web Portal

Providers can also submit inquiries via the GHP web portal at http://www.ghp.georgia.gov. GHP confirms receipt of web inquiries immediately with a confirmation page. GHP responds to your inquiries during normal business hours, 8 a.m. to 7 p.m., Monday through Friday.

Follow the steps below to submit an electronic inquiry to the Provider Inquiry Unit.

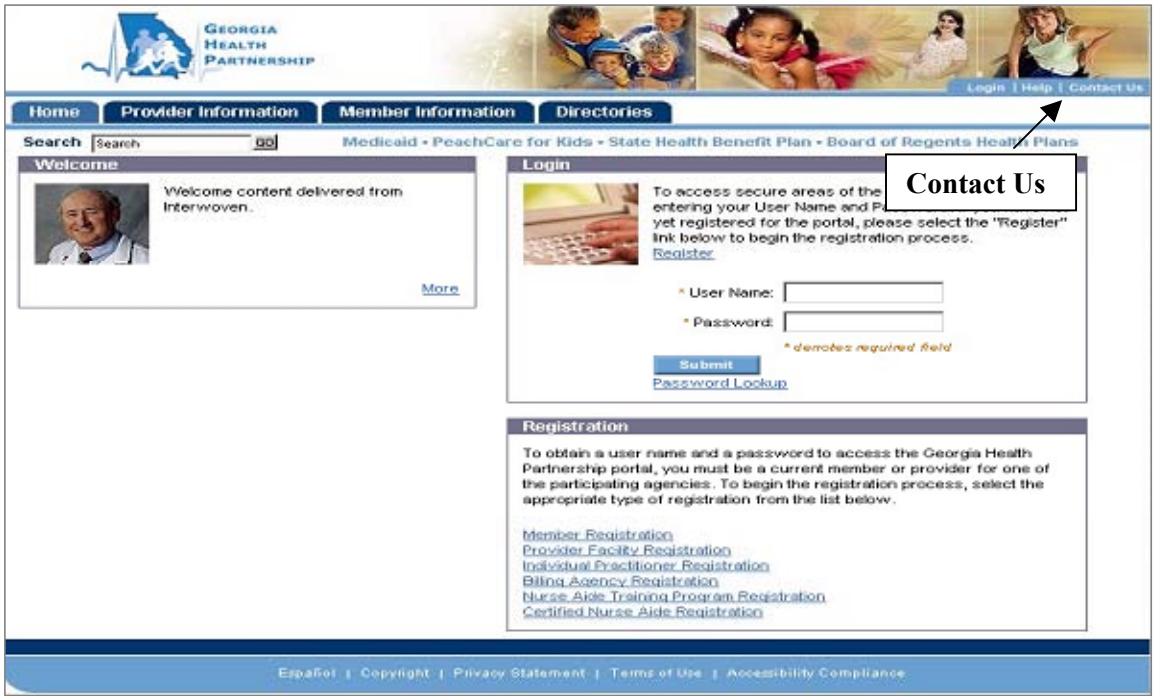


Figure 4-1. Contact Us Function on the Web Portal

1. Click the **Contact Us** link from any page of the web portal.

   For providers who have login capability, log into the web portal and then click the **Contact Us** link. After you click the link, the following Contact Us page appears.

Figure 4-2. Contact Us Page

The Contact Us page displays fields into which you enter basic demographic information. For providers who have already logged on, this information auto-populates with the provider information in the system. (You can override any of this information.)

2. For providers who do not have login information, please enter the following information into the entry fields:

   - Name
   - E-mail: this is the e-mail address to be used to communicate with you.
   - Address: this is the physical address of your office, practice, or facility.
   - Comments: this is where you provide information regarding your inquiry. We encourage you to provide as much detail as possible so we can adequately address your concerns.

The asterisk (shown next to any field) indicates that it is a required field.

Authenticated users may submit requests that would require disclosing individually identifiable health information (IIHI). Responses containing IIHI will be sent to the Message Center on the web portal. The provider will receive a message in their email account informing them that the response is available for pickup.

NOTE:
If detailed and demographic information is not submitted with your inquiry, the response to your inquiry might be delayed.

Members can also use the "Contact Us" feature to submit an inquiry to the Member Inquiry Unit.

3. Click the **Submit** button to submit your inquiry. After you click **Submit**, the Contact Us Confirmation page appears.

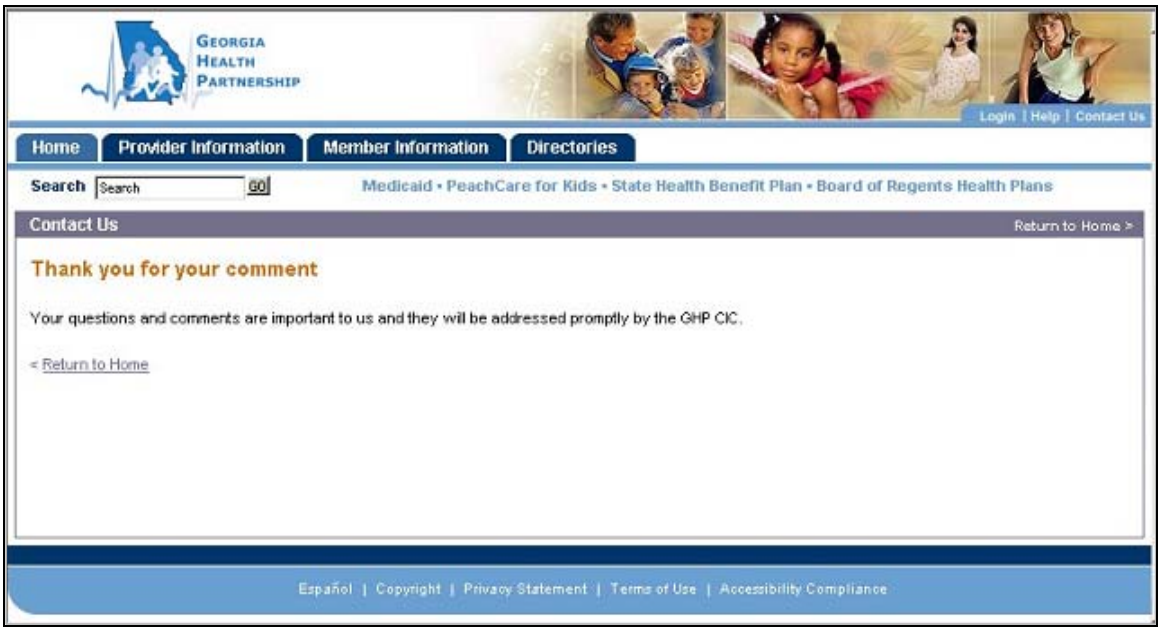


Figure 4-3. Contact Us Confirmation Page

The Contact Us confirmation page confirms that your inquiry has been received. From this page, you can navigate to the Home page or click the Provider Information, Member Information, or Directories tabs.

Every effort is made to respond to your inquiries. For unauthenticated providers using Contact Us, GHP uses the contact information entered on the Contact Us page. Make sure you enter the correct contact information in order to receive a response to your inquiry.

Some e-mail inquiry responses that include Individually Identifiable Health Information (IIHI) are sent to the provider's web portal Message Center. In this instance, the provider receives an e-mail notice to check the Message Center.

4.5.1 The U.S. Mail

You can reach the Provider Inquiry Unit by writing to:

Provider Inquiry Unit
P.O. Box 5000
McRae, GA 31055-5000

When writing the Provider Inquiry Unit (PIU) please photocopy and complete the provider inquiry form on the next page.

The Provider Inquiry Form (Figure 4-4) allows you to submit written requests to the Georgia Health Partnership via mail. In order to submit your written request, photocopy the form on the following page and fill in the appropriate information. Then, mail the form to the address shown at the top of the Provider Inquiry form.

4.5.1.1 Provider Inquiry Form (DMA-520)

GEORGIA HEALTH PARTNERSHIP

Provider Inquiry Form

Provider Number:

Provider Name and Address:

Telephone # ( ) ext.

Date of Inquiry:

Contact Person:

If this inquiry is about a member, please include the information requested below. Don't forget to indicate if the data was taken from an RA (Remittance Advice) or a claim.

Member Name: Last First Initial

Member ID Number:

Date of service:

Date of RA:

Data taken from: (Check one) ☐ RA ☐ Claim

Trans Control Number from RA:

INSTRUCTIONS:

* Use one form per inquiry.

* Select the appropriate box below for completion.

A. Medical Review Claim Inquiry. Use this box to inquire about one of the following Reason or Remark Codes. Please include supporting medical documentation.

Reason Code	Remark Code	Reason Code	Remark Code
119	M63	119	N59
18	N59	9	–
B5	M15	11	–
4	N59	B9	N66
97	N59	B9	N20, MA31, N54
A1	N59	62	MA31, N30

B. Non-Medical Review Claim Inquiry. Use this box when you want to inquire about the status of a claim submitted to GHP.

C. Prior Authorization Inquiry. Use this box when you receive a denial because you did not obtain a prior authorization. Please include supporting medical documentation.

D. General Inquiry. Use this box when you want to ask questions about GHP policies and procedures.

A MEDICAL REVIEW CLAIM INQUIRY
State the nature of your inquiry. Be as specific as possible.

Fax Form to: 866-483-1044

Mail form to: Georgia Health Partnership
Medical Review
PO Box 7000
McRae, GA 31055-7000

GHP USE ONLY

Response to inquiry:

C PRIOR AUTHORIZATION INQUIRY
State the nature of your inquiry. Be as specific as possible.

Fax Form to: 866-483-1044

Mail form to: Georgia Health Partnership
Medical Review
PO Box 7000
McRae, GA 31055-7000

Response to inquiry:

B NON-MEDICAL CLAIM INQUIRY
State the nature of your inquiry. Be as specific as possible.

Fax Form to: 866-483-1044

Mail form to: Georgia Health Partnership
Claims
PO Box 5000
McRae, GA 31055-5000

GHP USE ONLY

Response to inquiry:

D GENERAL INQUIRY
State the nature of your inquiry. Be as specific as possible.

Fax Form to: 866-483-1044

Mail form to: Georgia Health Partnership
Provider Inquiry Unit
PO Box 5000
McRae, GA 31055-5000

You may photocopy this form. DMA-520 (4/03)

Georgia Health Partnership, Provider Inquiry Form (4/03)

Figure 4-4. Provider Inquiry Form

5. Paper Claim Forms

Should you have the need to file a paper claim, the following information details the requirements for submission. To ensure proper payment, providers must complete and file the appropriate claim form(s).

5.1 Health Insurance Claim Form (CMS-1500)

The CMS-1500 form (formerly called HCFA-1500) is widely used by members of these service groups:

- Ambulance and other transportation services
- Community Care Services Program (CCSP)
- Community Habilitation and Support (CHSS)
- Community Mental Health services
- Diagnosis and treatment (Early and Periodic Screening, Diagnosis, and Treatment (EPSDT))
- Durable Medical Equipment (DME) suppliers
- Early and periodic screening services
- Family planning services
- Health department clinics
- Home health
- Independent Diagnostic Testing Facilities (IDTF)
- Independent Care Waiver Program (ICWP)
- Laboratories
- Mental Retardation Waiver Program (MRWP)
- Physicians and professional services
- Targeted Case Management (TCM) programs
    - At-Risk of Incarceration Case Management
    - Child Protective Services Case Management
    - Adult Protective Services Case Management
    - Adults with AIDS Case Management
    - Children At Risk Case Management

  - Perinatal Case Management"

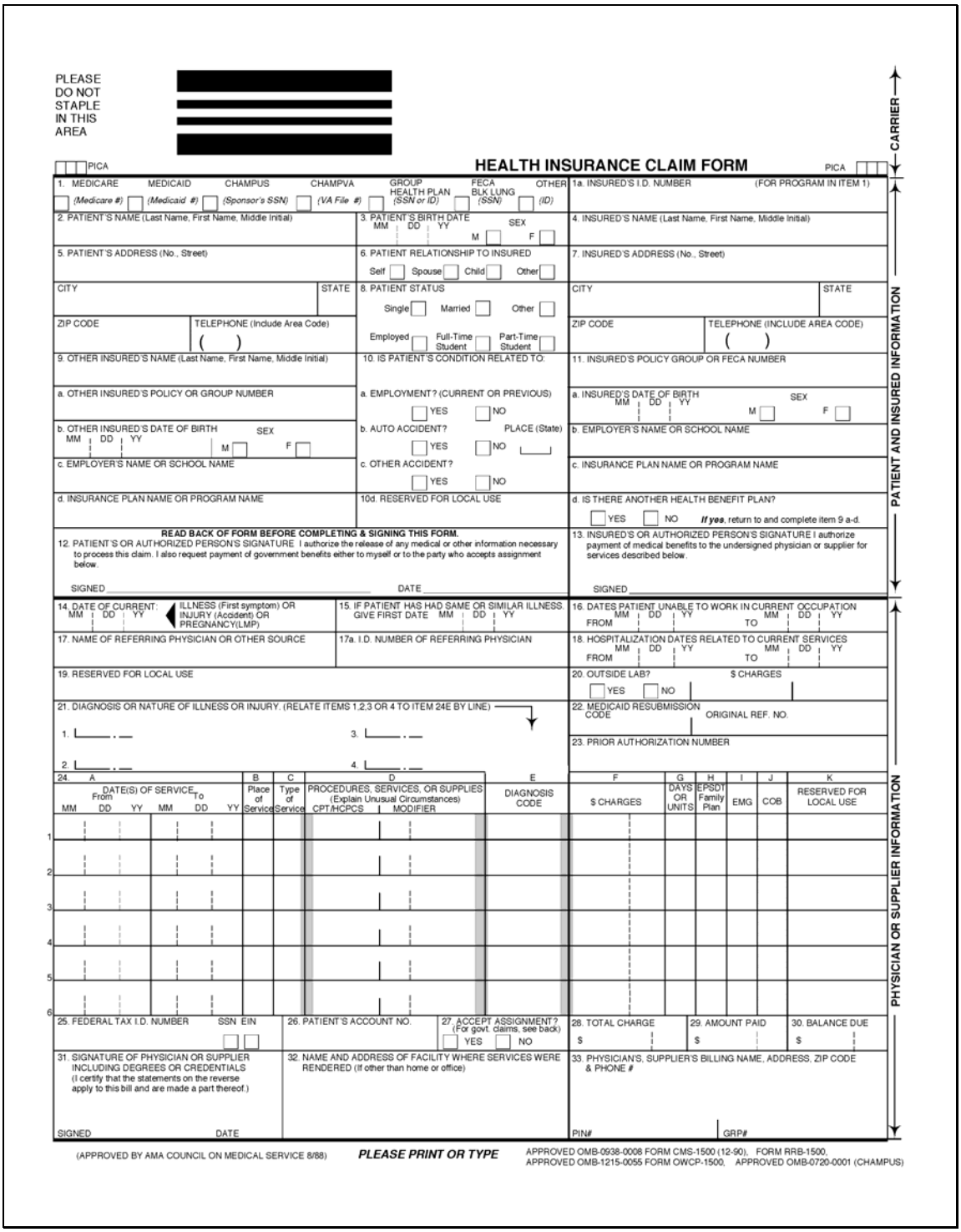
- Therapeutic Residential Intervention Services (TRIS)

- Vision, therapists (speech, physical, and occupational)

Claim(s) must be submitted within six months from the month of service. Claim(s) with third party resources must be submitted within 12 months from the month of service. Medicare crossover claims that are not automatically sent by the Medicare Carrier/Intermediary must be submitted within 24 month from the month of service.

5.1.1 Example of CMS-1500 Form

Following is an example of the Centers for Medicare and Medicaid Services 1500 (CMS-1500) form.



PLEASE DO NOT STAPLE IN THIS AREA

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

Figure 5-1. Example of CMS-1500 Form

5.1.2 CMS-1500 Form Field Descriptions

The following table provides a brief description of the fields located on the CMS-1500 Form. The alphanumeric data located in the **Form Locator** column identifies the area / location of the field on the CMS-1500 Form. (Data is entered in this area on the form.). The data located under the **Field Name** identifies and names the field for the given location. The alpha character located in the **Required Field** denotes the following:

- R - Required
- C - Conditionally required/if applicable

The information located in the **Comments** area explains what you should enter in each field.

Table 5-1. CMS-1500 Form Field Descriptions

Form Locator	Field Name	Required Field	Comments
1.	Health insurance coverage	R	Check all appropriate boxes for coverage.
1a.	Insured's ID number	R	Enter the member's Medicaid number exactly as it appears on the eligibility card.
2.	Patient's name	R	Enter Medicaid member's name exactly as it appears on the eligibility card, last name first.
3.	Patient's birth date and sex	C	Enter member's date of birth (using the MM/DD/YY format) and gender.
4.	Insured's name	C	Enter insured's name ONLY if other insurance (third party). Medicare is NOT considered other insurance. Enter only the member name for Medicaid/PeachCare claims.
5.	Patient's address	C	Enter member's full and correct address.
6.	Patient relationship to insured	C	Enter relationship, if applicable.
7.	Insured's address	C	Enter address, if applicable.
8.	Patient's status	R	Indicate marital status, if employed or if student.
9.	Other insured's name	C	Enter the primary insurance subscriber/policyholder's name.
9a.	Other insured's policy or group number	C	Enter the primary insurance policy number.
9b.	Other insured's date of birth and sex	C	Enter the primary insurance subscriber/policyholder date of birth.
9c.	Employer's name/school name	C	Enter the primary insurance subscriber/policyholder's employer's name.
9d.	Insurance plan name or program name	C	Enter only primary insurance information, if Medicaid is secondary payer.
10a.	Is patient's condition related to employment?	R	Enter "X" if treatment related to employment.
10b.	Is patient's condition related to auto accident?	R	Enter "X" if treatment is related to auto accident.
10c.	Is patient's condition related to other accident?	R	Enter "X" if treatment is related to other accident.
10d.	Reserved for local use		
11.	Insured's policy group or FECA number	C	Enter number of any other insurance plan, if applicable. When billing Medicaid/PeachCare for Kids, data is not required in this field.

Form Locator	Field Name	Required Field	Comments
11a.	Insured's date of birth and sex	C	Enter date of birth and gender, if applicable. Enter date using MM/DD/YY format. When billing Medicaid/PeachCare for Kids, data is not required in this field.
11b.	Employer's name/school name	C	Enter employer's name or school name, if applicable. When billing Medicaid/PeachCare for Kids, data is not required in this field.
11c.	Insurance plan or benefit plan being billed	C	Enter insurance plan or program name, if applicable. When billing Medicaid/PeachCare for Kids, data is not required in this field.
11d.	Other health benefit plan	C	Indicate whether another coverage or insurance plan exists. If "YES", the provider should complete items 9 – 9d on the CMS-1500 form.
12.	Patient's or authorized person's signature and date	R	Enter the signature and date using the MM/DD/YY format.
13.	Insured or authorized person's signature	C	Enter signature, only if third party payer.
14.	Date of current illness, injury and/or pregnancy	R	Enter date in MM/DD/YY format. And, if for pregnancy, give date of LMP. *Note:* If "YES" is indicated in field 10a – 10c, enter an accident date for this field.
15.	Previous date of same or similar illness	C	Enter date in MM/DD/YY format, if applicable.
16.	Dates patient unable to work	C	Enter date in MM/DD/YY format, if applicable.
17.	Name of referring physician or other source	C	Enter name, if applicable.
17a.	Referring physician's ID number	C	Enter referring physician's Medicaid provider number, or Universal Provider Identification Number (UPIN) or state license number and if GBHC member, enter GBHC referral number, if applicable.
18.	Hospitalization dates	C	Enter hospitalization dates related to current services, using the "from-through" format, if applicable.
19.	Reserved for local use		
20.	Outside lab	C	Check "YES" or "NO" (charges are not necessary).
21.	Diagnosis or nature of illness or injury	C	Enter International Classification of Disease, 9th Revision, Clinical Modification (ICD-9 CM) code(s) related to service billed. List code(s) priority order (primary, secondary, and so forth).
22.	Medicaid resubmission code/original reference number	C	Enter the Transaction Control Number (TCN) of the previous/original claim, if this is for an adjustment.
23.	Prior authorization number	C	Enter the prior authorization number or pre-certification number (PA/PC) issued by Georgia Medical Care Foundation (GMCF), if applicable.
24a.	Date(s) of service	R	Enter first Date of Service (DOS) in the "From" space and the last DOS in the "To" space. If services are only for one date, enter the date twice using the MM/DD/YY format.
24b.	Place of service	R	Enter valid and appropriate two digit codes for place of service.
24c.	Type of service	C	Enter valid and appropriate code(s) for type of service.
24d.	Procedure/services/supplies	R	Enter appropriate five digits Current Procedural Terminology (CPT-4) or Health Care Financing Administration Common Procedural Coding System (HCPCS) code(s) that describe procedure/services/supplies. Use modifiers, if appropriate.
24e.	Diagnosis code	R	Enter the number (1,2,3,4) of the diagnosis code entered in Field 21 for which this service was rendered. *Do not* enter the ICD-9 or DSM diagnosis code

Form Locator	Field Name	Required Field	Comments
24f.	Charges	R	Enter the total charge(s) for procedure/services/supplies.
24g.	Days/units	R	Enter the number of times the procedure for which you are billing was performed.
24h.	EPSDT/family planning	C	If services were provided from a referral from Health Check (formally Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)) enter "ET". *Note*: The Health Check program is only for those under 21 years of age. If services were for Family Planning purposes, enter "FP". This field is required for all Health Check/Family Planning procedure codes billed on claim. If neither applies, leave blank.
24i.	EMG	C	If the procedure code billed was the result of an emergency, enter "Y" for Yes.
24j.	COB	C	Must indicate and enter valid value for any other health insurance coverage. Valid values: *1* - No other health insurance *2* - Medicare *3* - Other insurance
24k.	Reserved for local use		
25.	Federal tax ID number	R	Enter Social Security Number (SSN) or Employee Identification Number (EIN).
26.	Patient account number	C	Enter the patient's record number used internally by your office.
27.	Accepts assignment	R	Billing Medicaid indicates acceptance of assignment.
28.	Total charge	R	Enter the total of the charges listed for each line.
29.	Amount paid	C	Enter only the total amount paid by other insurance. *Note*: Do not enter Medicaid copayments collected at the time of service into this field.
30.	Balance Due	R	Enter submitted charge, less any third party payment received.
31.	Signature of physician or supplier and date	R	Provider must sign (or signature stamp) and provide degrees or credentials. Enter the current date. *Note:* Unsigned invoice/claims forms cannot be accepted for processing.
32.	Name and address of facility	R	Enter name and address where services were rendered (e.g., hospital, home, etc.).
33.	GRP number	C	Enter Medicaid group pay-to-provider number, if applicable.

5.1.3 Date of Service Requirements

Please review the following Category of Services (COS) before completing the CMS-1500 form. This information explains the Dates of Services (DOS) requirements necessary when completing the CMS-1500 form:

- **Physician**, **Podiatry**, **Advanced Nurse Practitioner**, **Nurse-Midwifery**, **and Vision programs** allow the DOS to span only if the date span falls within the same calendar year (December 31 through January 1) or state fiscal year (June 30 through July 1).

- **Service Options Using Resources in Community Environments (SOURCE)** does not span into another month (only one month at a time).

- **Community Care Services Program (CCSP)** requires providers to bill one month per claim. Overlapping one month to the next is not allowed.

- **Children Intervention Services (CIS)** and **Children Intervention School Services (CISS)** do not allow providers to span their dates of service.

- **Health Check** is not allowed to span DOS.

- **Children At Risk Targeted Case Management** is allowed to span dates, but the provider bills the From Date of Services (FDOS) and To Date of Services (TDOS) as the last day of every month.

- **Model Waiver Program**, **Exceptional Children's Service** and the **Georgia Pediatric Program (GAPP)** do not allow providers to span their dates of service.

- Dates of Services in **Mental Retardation Waiver Program (MRWP) (680)** and **Community Habilitation and Support (CHSS) (681)** are allowed to span within the month or for a month. Cannot cross over from one month to the next.

- **Ambulance Services**

5.2 UB-92 Form

Following is an example of the UB-92 Form. The UB-92 claim form (also known as the CMS-1450) is widely used by members of these service groups:

- Hospitals (inpatient/outpatient services)

- Hospice

- Nursing home

- Swing bed

- Ambulatory surgical center/birthing centers

- Hospital-based rural health centers

- Dialysis facilities (that are billing the technical component)

- Intermediate Care Facility for Mentally Retarded (ICF/MR).

- Ambulance Services (Medicare crossover only)

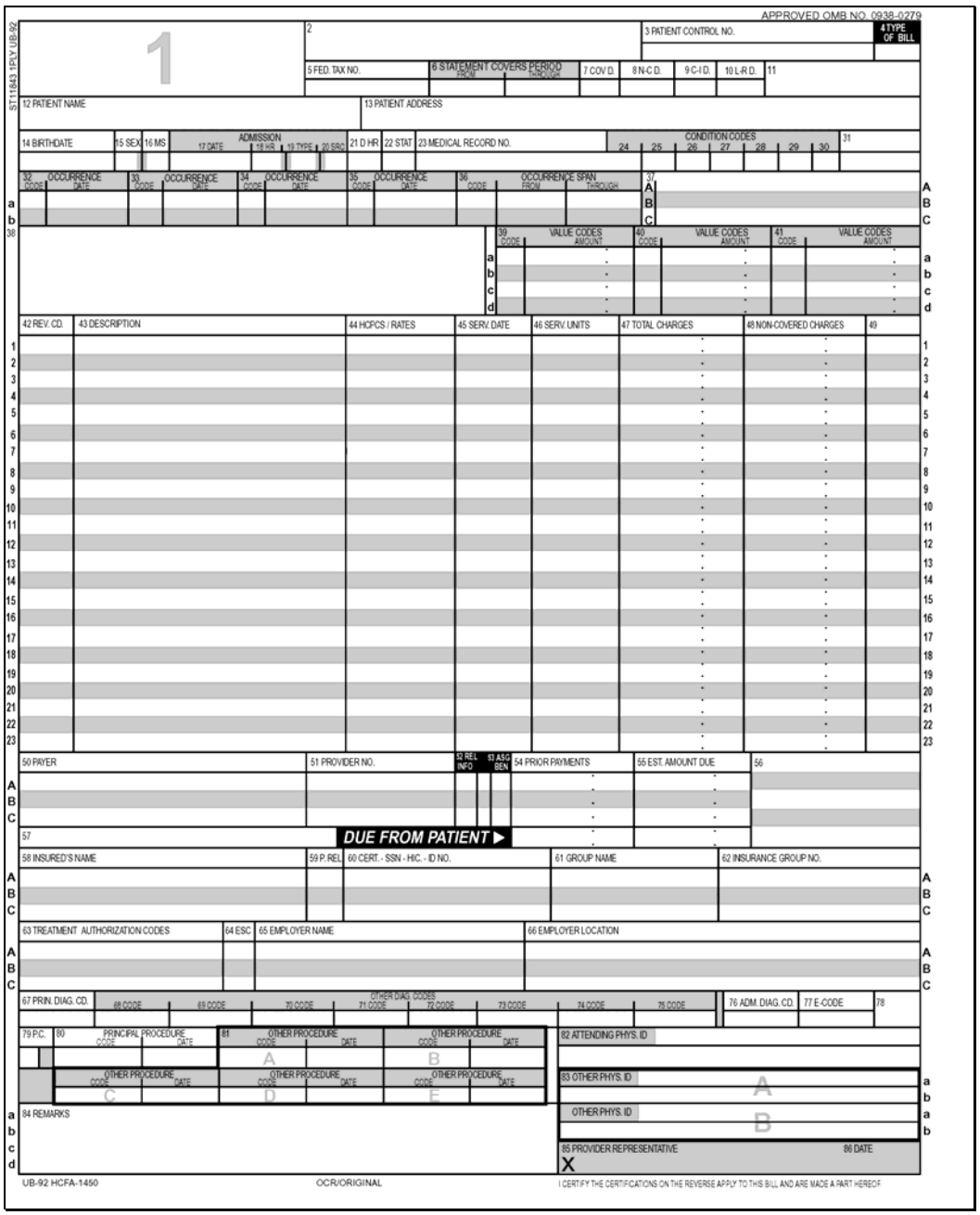


Figure 5-2. UB-92 Form

5.2.1 UB-92 Form Field Description

The following table provides a brief description of the fields located on the UB-92 Form. The alphanumeric data located in the **Form Locator** column identifies the area / location of the field on the UB-92 Form. (Data is entered in this area on the form.) The data located in the **Field Name** column identifies and names the field for the given location. The alpha character shown in the **Required Field** denotes the following:

- R - Required
- C - Conditionally required/if applicable
- RI - Required inpatient
- RO - Required outpatient
- Blank - Not required

The information located under the **Comments** area explains what you should enter in the given field.

Table 5-2. UB-92 Form Field Descriptions

Form Locator	Field Name	Required Field	UB-92 Comments
1.	Provider Name, Address, Phone number and Fax number	R	Enter the provider name, address, phone number, and fax number.
2.	State Assigned		
3.	Patient Control Number		Use the patient's medical record number printed on the remittance voucher. If this is the first claim the provider is submitting for the member and there is no remittance advice, enter the patient's unique alphanumeric medical record number assigned by the provider to facilitate retrieval of the individual case records and posting of payment.
4.	Type of Bill	R	Enter the appropriate digit code and frequency for bill type.
5.	Federal Tax ID number	R	Enter the provider's federal identification number.
6.	Statement Covers Period	R	Enter the dates of service covered by claim (from-through date).
7.	Covered Days	C	Enter the number of days covered by the claim.
8.	N-CD (Non-Covered Days)	RI	
9.	C-ID (Co-Insurance Days)		
10.	L-RD (Lifetime Reserve Days)		
11.	State assigned		
12.	Patient's Name	R	Enter the member's name: first, middle initial, and last name
13.	Patient's Address	C	Enter the member's complete address.
14.	Birth Date	R	Enter the member's date of birth (use MM/DD/YY format).
15	Sex		Enter the member's gender.
16.	MS		Enter the member's marital status.
17.	Admission Date	RI	Enter the member's date of admission.

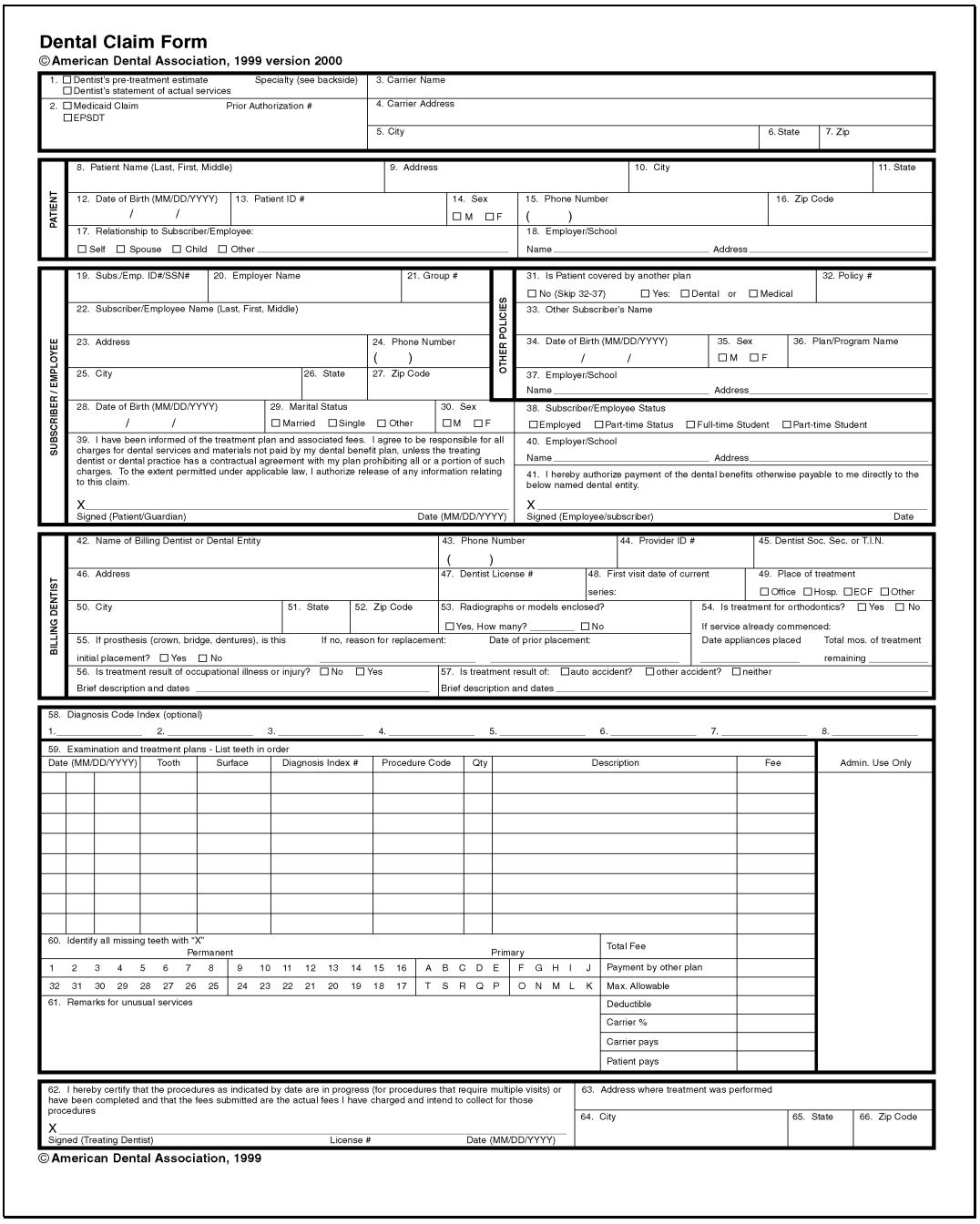
Form Locator	Field Name	Required Field	UB-92 Comments
18.	Admission Hour	C	Enter the member's time of admission.
19.	Admission Type	RI	Enter the member's type of admission.
20.	Admission SRC	RI	Enter the member's source of admission.
21.	D HR	C	Enter the hour (00-23) that the patient was discharged from inpatient care if there is a discharge code in field 22..
22.	STAT	RI	Enter the member's status at discharge.
23.	Medical Record (MR) number		Enter the member's MR number, if applicable.
24. - 30.	Condition Codes	C	Enter the condition code(s), if applicable.
31.	Not assigned		
32. - 35.	Occurrence Code(s) and Date(s)	C	Enter occurrence code(s) and dates, if applicable.
36.	Occurrence Span	C	Enter appropriate code and from-through date, if applicable.
37.	Document Control Number	C	Enter original TCN, if the claim is an adjustment of a previous claim.
38.	Responsible Party Name and Address		Enter name and address of responsible party, if applicable.
39. - 41.	Value Code(s) and Amount(s)	C	Enter valid value codes(s) for deductible payer A, B, C, and co-insurance payer A, B, C.
42.	Revenue Code	R	Enter appropriate revenue code.
43.	Description	R	Using one line for each, enter description of service(s) / procedure(s) provided.
44.	HCPCS/Rates	RO	Enter appropriate Current Procedural Terminology (CPT-4) or HCPCS procedure code(s).
45.	Service Date	RO	Enter the line item service date.
46.	Service Units	R	Enter the number of times the procedure, for which you are billing, was performed.
47.	Total Charges	R	Enter the total amount of charges for service(s) / procedure(s) performed.
48.	Non-Covered Charges	C	Enter charge, if applicable.
49.	Not Assigned		
50.	Payer (A, B, C)	C	Enter payers in order of benefit determination (A=Primary, B=Secondary, C=Tertiary) and enter amount in form locator 54, if applicable.
51.	Provider number (A, B, C)	R	Enter Medicaid provider number.
52.	Release of Information		
53.	Assignment of Benefits		
54.	Prior Payments (A, B, C)	C	Other insurance and/or Medicare payments associated with payers in form locator 50
55.	Estimated Amount Due from Patient		
56.	State Assigned		
57.	Not Assigned		
58.	Insured's Name	C	Enter name, if applicable.
59.	Patient's Relationship to Insured	C	Enter relationship, if applicable.
60.	SSN/HIC (Social Security Number/Health Insurance Claim) or ID number	R	Enter Medicaid member's identification number on the Medicaid card or the approval letter (for the member being treated) to the line associated with Medicaid in field locator box 50. Enter appropriate ID numbers for any other payers identified in field locator box 50.

Form Locator	Field Name	Required Field	UB-92 Comments
61.	Group Name		Enter other payer's group/employer name.
62.	Insurance Group number		Enter number, if applicable.
63.	Treatment Authorization Code(s)	C	Enter prior authorization number, if applicable. The claim must be split if more than one prior authorization applies.
64.	Employment Status Code		
65.	Employer Name		Enter name, if applicable.
66.	Employer Location		Enter location, if applicable.
67.	Principle Diagnosis Code	R	Enter appropriate ICD-9 diagnosis code.
68. - 75.	Other Diagnosis Codes	C	Enter appropriate ICD-9 diagnosis codes, if applicable.
76.	Admitting Diagnosis Code	C	Enter appropriate ICD-9 diagnosis code, if applicable.
77.	E-Code	C	Enter appropriate ICD-9 E-Code if admission is accident related.
78.	State Assigned		
79.	Procedure Coding		
80.	Principle Procedure Code and Date	C	Enter appropriate CPT-4 or HCPCS procedure code, if applicable.
81.	Other Procedure Codes and Dates	C	Enter appropriate CPT-4 or HCPCS procedure code(s) number dates, if applicable.
82.	Attending Physician ID number	C	Enter attending physician Universal Provider Identification Number (UPIN), National Provider Identification (NPI), or Medicaid provider number, if applicable.
83.	Other Physician ID number	C	Enter PAAS approval number(s) in "other physician" space(s), if applicable.
84.	Remarks		
85.	Provider Representative	R	Signature of person authorized to certify this claim. *Note:* By signing, you certify that all information on the claim for Medicaid reimbursement is true, accurate, and complete.
86.	Date	R	Enter the date you are submitting the claim.

5.3 American Dental Association (ADA) Form

Following is an example of the ADA Form. The ADA claim form is widely used by these service groups:

- Dentists
- Orthodontists



Dental Claim Form

©American Dental Association, 1999 version 2000

1. ☐ Dentist's pre-treatment estimate ☐ Dentist's statement of actual services — Specialty (see backside)
2. ☐ Medicaid Claim ☐ EPSDT — Prior Authorization #
3. Carrier Name
4. Carrier Address
5. City | 6. State | 7. Zip

PATIENT

8. Patient Name (Last, First, Middle) | 9. Address | 10. City | 11. State
12. Date of Birth (MM/DD/YYYY) / / | 13. Patient ID # | 14. Sex ☐ M ☐ F | 15. Phone Number ( ) | 16. Zip Code
17. Relationship to Subscriber/Employee: ☐ Self ☐ Spouse ☐ Child ☐ Other
18. Employer/School Name Address

SUBSCRIBER / EMPLOYEE

19. Subs./Emp. ID#/SSN# | 20. Employer Name | 21. Group #
22. Subscriber/Employee Name (Last, First, Middle)
23. Address | 24. Phone Number ( )
25. City | 26. State | 27. Zip Code
28. Date of Birth (MM/DD/YYYY) / / | 29. Marital Status ☐ Married ☐ Single ☐ Other | 30. Sex ☐ M ☐ F
39. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.
X Signed (Patient/Guardian) Date (MM/DD/YYYY)

OTHER POLICIES

31. Is Patient covered by another plan ☐ No (Skip 32-37) ☐ Yes: ☐ Dental or ☐ Medical | 32. Policy #
33. Other Subscriber's Name
34. Date of Birth (MM/DD/YYYY) / / | 35. Sex ☐ M ☐ F | 36. Plan/Program Name
37. Employer/School Name Address
38. Subscriber/Employee Status ☐ Employed ☐ Part-time Status ☐ Full-time Student ☐ Part-time Student
40. Employer/School Name Address
41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.
X Signed (Employee/subscriber) Date

BILLING DENTIST

42. Name of Billing Dentist or Dental Entity | 43. Phone Number ( ) | 44. Provider ID # | 45. Dentist Soc. Sec. or T.I.N.
46. Address | 47. Dentist License # | 48. First visit date of current series: | 49. Place of treatment ☐ Office ☐ Hosp. ☐ ECF ☐ Other
50. City | 51. State | 52. Zip Code | 53. Radiographs or models enclosed? ☐ Yes, How many? _____ ☐ No | 54. Is treatment for orthodontics? ☐ Yes ☐ No If service already commenced: Date appliances placed Total mos. of treatment remaining
55. If prosthesis (crown, bridge, dentures), is this initial placement? ☐ Yes ☐ No — If no, reason for replacement: — Date of prior placement:
56. Is treatment result of occupational illness or injury? ☐ No ☐ Yes — Brief description and dates
57. Is treatment result of: ☐ auto accident? ☐ other accident? ☐ neither — Brief description and dates

58. Diagnosis Code Index (optional)
1. 2. 3. 4. 5. 6. 7. 8.

59. Examination and treatment plans - List teeth in order

Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee	Admin. Use Only

60. Identify all missing teeth with "X"

Permanent																Primary										Total Fee	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J	Payment by other plan	
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	Max. Allowable	

61. Remarks for unusual services

Deductible
Carrier %
Carrier pays
Patient pays

62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures
X Signed (Treating Dentist) License # Date (MM/DD/YYYY)

63. Address where treatment was performed
64. City | 65. State | 66. Zip Code

©American Dental Association, 1999

Figure 5-3. ADA Dental Form

5.3.1 ADA Form Field Descriptions

The following table provides a brief description of the fields located on the ADA claim form. The alphanumeric data located under the **Form Locator** column identifies the area / location of the field on the ADA claim form. (Data is entered in this area on the form.) The data located under the **Field Name** column identifies and names the field for the given location. The alpha character located in the **Required Fields** denotes the following:

- R - Required
- C - Conditionally required/if applicable
- Blank - Not required

The information located under the **Comments** column explains what you enter in each field.

Table 5-3. ADA Form Field Descriptions

Form Locator	Field name	Required Fields	Comments
1.	Dentist pre-treatment estimate/statement of actual services/specialty	R	Complete appropriate box to expedite processing and decrease chance of error.
2.	Medicaid claim/EPSDT/Prior authorization number	C	Complete if applicable.
3. - 7.	Carrier name and address	R	Complete full and accurate name and address.
8.	Patient name	R	Enter member's last name followed by first name and middle initial.
9. -11.	Patient's address	R	Enter member's complete address.
12.	Date of birth	R	Enter member's birth date, using MM/DD/YY format.
13.	Patient's ID number	R	Enter member's Medicaid ID number.
14.	Gender	R	Enter whether patient is male or female.
15.	Phone number	R	Enter the patient's phone number.
16.	Zip code	R	Enter the patient's zip code.
17.	Relationship to subscriber/employee	C	Enter if applicable.
18.	Employer/school	C	Enter name and address, if applicable. Enter number, if applicable.
19.	Subscriber/employee/insured ID number/SSN	C	Enter this information for insured person. (This may not necessarily be the patient.)
20.	Employer's name	C	Enter name, if applicable.
21.	Group number	C	Enter number, if applicable.
22. - 27.	Subscriber/employee name, address, phone number	C	Enter complete name and address, if applicable.
28.	Subscriber birth date	C	Enter date, if applicable using MM/DD/YY format.
29.	Subscriber's marital status	C	Enter the marital status, if applicable
30.	Subscriber's gender	C	Enter the patient's gender, if applicable.
31.	Is patient covered by another plan (dental/medical)	R	If "NO", skip to 38. If "YES", continue entering for 32 - 37.
32.	Policy number	R	Enter policy number, if applicable.
33.	Other subscriber name	C	Enter subscriber name, if applicable.
34.	Subscriber's date of birth	C	Enter date of birth, if applicable and use MM/DD/YY format.
35.	Subscriber's gender	C	Enter subscriber's gender, if applicable.
36.	Plan/program name	C	Enter plan/program name, if applicable.
37.	Employer/school name and address	C	Enter employer, school name, and address, if applicable.
38.	Subscriber/employee name	R	Enter appropriate employment and/or student status.
39.	Signature of patient/recipient and date	R	The patient signature and date indicates that the member is informed of the treatment plan and fees. This information also authorizes release of any information relating to this claim.
40.	Employer/school	C	Refers to person in form locator 22. Maybe necessary for COB. Enter name and address, if applicable.

Form Locator	Field name	Required Fields	Comments
41.	Signature and date of patient/employee/subscriber	R	The signature and date are necessary for benefits to be paid directly to provider. This is an authorization of payment and does not constitute an assignment of benefits.
42.	Name of provider	R	Enter the individual dentist's name or the name of the group practice/corporation responsible for billing and other pertinent information. (This may differ from the actual treating dentist's name.)
43.	Provider phone number	R	Enter the provider's phone number.
44.	Provider ID number	R	Enter the provider's identification number.
45.	Provider SSN or TIN	R	Enter the provider's social security number or tax identification number.
46.	Provider address	R	Enter the provider's address.
47.	Provider license number	R	Enter the provider's license number.
48.	Date of first visit	R	Enter the first visit date of current series of treatment.
49.	Place of treatment	R	Check appropriate box (office, hospital, extended care facility (ECF) or other, etc.).
50.	Provider city	R	Enter the city.
51.	Provider state	R	Enter the state.
52.	Provider zip	R	Enter the zip code.
53.	Radiographs/models enclosed	R	Indicate "YES" or "NO" and the number of diagnostic materials sent.
56.	Occupational illness or injury	R	Indicate "YES" or "NO" with brief description and dates, if treatment is result of occupational illness or injury, which may result in worker's compensation claim.
57.	Treatment result of accident	R	Indicate brief description with dates, if treatment due to auto accident, other accident, or neither.
58.	Diagnosis code	B	Enter five digit ADA diagnosis code(s).
59.	Examination and treatment plan	R	Enter date of service using MM/DD/YY format, tooth number, surface, and diagnosis index number. (Enter the index number 1 - 8 for as many diagnoses as necessary for each procedure code.) When member has more than one diagnosis per procedure, separate index number with a comma. For a procedure code, use the appropriate ADA CPT-3 code(s). If procedure is performed multiple times, record procedure code once and the frequency in the quantity (qty.) column. **Be sure to enter a value in the quantity field when submitting electronic claims.** If you submit claims via the web, WINASAP, a clearing house, or software from a software vendor, HIPAA standards require you to complete the quantity/units field. Describe as necessary. Enter fee amount for each service and total.
60.	Missing teeth	C	Identify all missing teeth with an "X".
61.	Remarks	C	Indicate any information you feel may be helpful in determining benefits for the treatment.
62.	Provider signature, license number, and date	R	Enter the treating dentist's signature, license number, and date of service.
63. - 66.	Address	R	Indicate address where treatment was performed, if performed at a different location than indicated in boxes 46 and 50 - 52.

5.4 Pharmacy Universal Claim Form

An example of the Pharmacy Universal Claim Form is provided below. Pharmacists use this form to file all claims. You can purchase these forms by contacting Moore North America at (800) 635-9500.

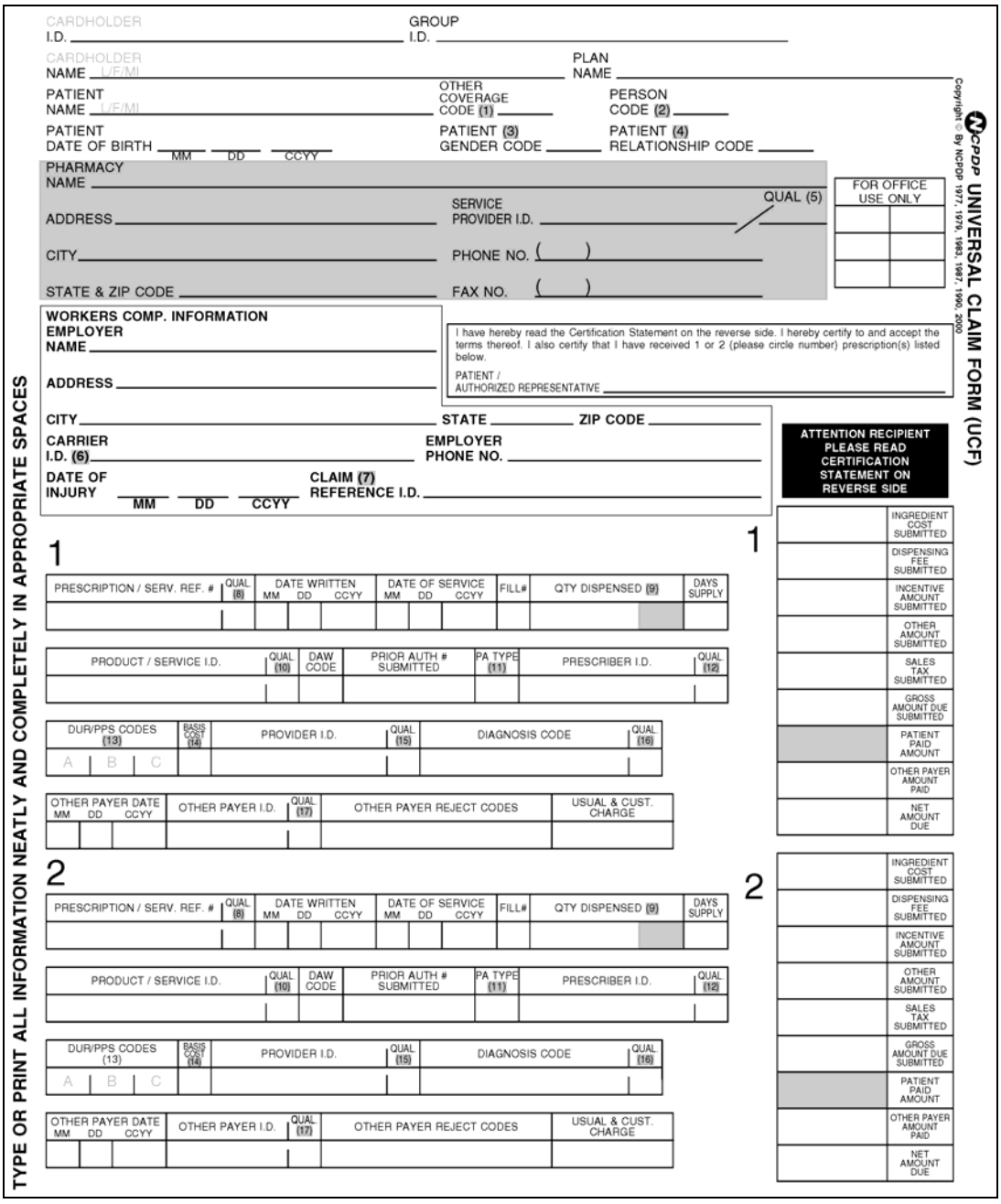


Figure 5-4. Pharmacy Universal Claim Form

NOTE:
Pharmacy claims will continue to go to Express Scripts, Inc. (ESI).

Following is page two of the Pharmacy Universal Claim Form. It is located on the back of the Pharmacy Universal Claim form. The information on the back of this form provides instructions for filling out the form and explains the fields on the front of the form.

IMPORTANT I certify that the patient information entered on the front side of this form is correct, that the patient named is eligible for the benefits and that I have received the medication described. If this claim is for a workers compensation injury, the appropriate section on the front side has been completed. I hereby assign the provider pharmacy any payment due pursuant to this transaction and authorize payment directly to the provider pharmacy. I also authorize release of all information pertaining to this claim to the plan administrator, underwriter, sponsor, policyholder and the employer.

PLEASE SIGN CERTIFICATION ON FRONT SIDE FOR PRESCRIPTION(S) RECEIVED

INSTRUCTIONS

1. Fill in all applicable areas on the front of this form.
2. Enter COMPOUND RX in the Product Service ID area(s) and list each ingredient, name, NDC, quantity, and cost in the area below. Please use a separate claim form for each compound prescription.
3. Worker's Comp. Information is conditional. It should be completed only for a Workers Comp. Claim.
4. Report diagnosis code and qualifier related to prescription (limit 1 per prescription).
5. Limit 1 set of DUR/PPS codes per claim.

DEFINITIONS / VALUES

1. OTHER COVERAGE CODE

0=Not Specified; 1=No other coverage identified; 2=Other coverage exists-payment collected
3=Other coverage exists-this claim not covered; 4=Other coverage exists-payment not collected; 5=Managed care plan denial
6=Other coverage denied-not a participating provider; 7=Other coverage exists-not in effect at time of service; 8=Claim is billing for a copay

2. PERSON CODE: Code assigned to a specific person within a family.

3. PATIENT GENDER CODE

0=Not Specified; 1=Male; 2=Female

4. PATIENT RELATIONSHIP CODE

0=Not Specified; 1=Cardholder; 2=Spouse
3=Child; 4=Other

5. SERVICE PROVIDER ID QUALIFIER

Blank=Not Specified; 01=National Provider Identifier (NPI); 02=Blue Cross
03=Blue Shield; 04=Medicare; 05=Medicaid
06=UPIN; 07=NCPDP Provider ID; 08=State License
09=Champus; 10=Health Industry Number (HIN); 11=Federal Tax ID
12=Drug Enforcement Administration (DEA); 13=State Issued; 14=Plan Specific
99=Other

6. CARRIER ID: Carrier code assigned in Worker's Compensation Program.

7. CLAIM/REFERENCE ID: Identifies the claim number assigned by Worker's Compensation Program.

8. PRESCRIPTION/SERVICE REFERENCE # QUALIFIER

Blank=Not Specified; 1=Rx billing; 2=Service billing

9. QUANTITY DISPENSED: Quantity dispensed expressed in metric decimal units (shaded areas for decimal values).

10. PRODUCT/SERVICE ID QUALIFIER: Code qualifying the value in Product/Service ID (407-07)

Blank=Not Specified; 00=Not Specified; 01=Universal Product Code (UPC)
02=Health Related Item (HRI); 03=National Drug Code (NDC); 04=Universal Product Number (UPN)
05=Department of Defense (DOD); 06=Drug Use Review/Professional Pharm. Service (DUR/PPS); 07=Common Procedure Terminology (CPT4)
08=Common Procedure Terminology (CPT5); 09=HCFA Common Procedural Coding System (HCPCS); 10=Pharmacy Practice Activity Classification (PPAC)
11=National Pharmaceutical Product Interface Code (NAPPI); 12=International Article Numbering System (EAN); 13=Drug Identification Number (DIN)
99=Other

11. PRIOR AUTHORIZATION TYPE CODE

0=Not Specified; 1=Prior authorization; 2=Medical Certification
3=EPSDT (Early Periodic Screening Diagnosis Treatment); 4=Exemption from copay; 5=Exemption from Rx limits
6=Family Planning Indicator; 7=Aid to Families with Dependent Children (AFDC); 8=Payer Defined Exemption

12. PRESCRIBER ID QUALIFIER: Use service provider ID values.

13. DUR/PROFESSIONAL SERVICE CODES: Reason for Service, Professional Service Code, and Result of Service. For values refer to current NCPDP data dictionary.

A=Reason for Service; B=Professional Service Code; C=Result of Service

14. BASIS OF COST DETERMINATION

Blank=Not Specified; 00=Not Specified; 01=AWP (Average Wholesale Price)
02=Local Wholesaler; 03=Direct; 04=EAC (Estimated Acquisition Cost)
05=Acquisition; 06=MAC (Maximum Allowable Cost); 07=Usual & Customary
09=Other

15. PROVIDER ID QUALIFIER

Blank=Not Specified; 01=Drug Enforcement Administration (DEA); 02=State License
03=Social Security Number (SSN); 04=Name; 05=National Provider Identifier (NPI)
06=Health Industry Number (HIN); 07=State Issued; 99=Other

16. DIAGNOSIS CODE QUALIFIER

Blank=Not Specified; 00=Not Specified; 01=International Classification of Diseases (ICD9)
02=International Classification of Diseases (ICD10); 03=National Criteria Care Institute (NDCC); 04=Systemized Nomenclature of Human and Veterinary Medicine (SNOMED)
05=Common Dental Term (CDT); 06=Medi-Span Diagnosis Code; 07=American Psychiatric Association Diagnostic Statistical Manual of Mental Disorders (DSM IV)
99=Other

17. OTHER PAYER ID QUALIFIER

Blank=Not Specified; 01=National Payer ID; 02=Health Industry Number (HIN)
03=Bank Information Number (BIN); 04=National Association of Insurance Commissioners (NAIC); 09=Coupon
99=Other

COMPOUND PRESCRIPTIONS - LIMIT 1 COMPOUND PRESCRIPTION PER CLAIM FORM.

Name	NDC	Quantity	Cost

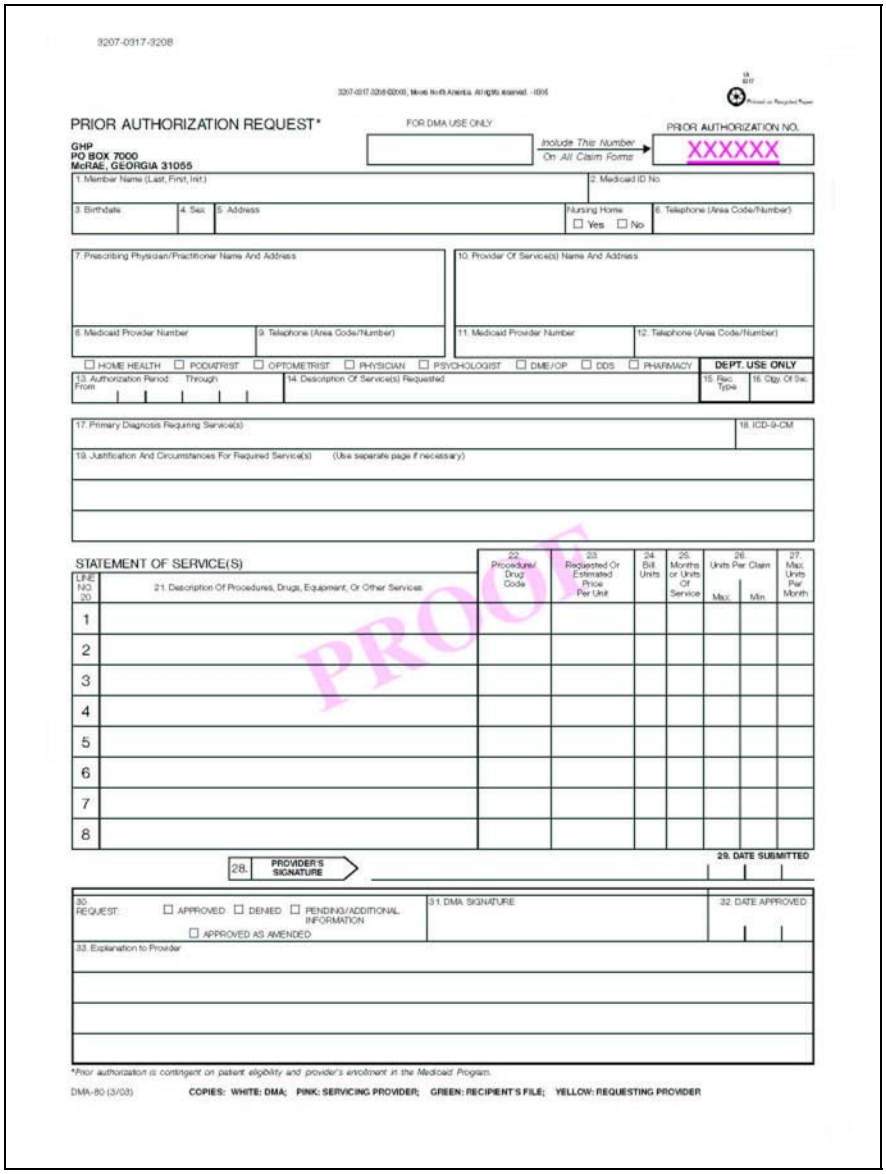
Figure 5-5. Pharmacy Universal Claim Form (Page 2)

6. Miscellaneous Forms and Attachments

This section contains examples of the miscellaneous forms and attachment used for billing.

6.1 Prior Authorization Request Form (DMA-80)

This form is used to reflect the services that have been authorized for the member. This process is available on the web, attachment free in most instances.



3207-0317-3208

PRIOR AUTHORIZATION REQUEST*

FOR DMA USE ONLY

PRIOR AUTHORIZATION NO.

Include This Number On All Claim Forms

XXXXXX

GHP
PO BOX 7000
McRAE, GEORGIA 31055

1. Member Name (Last, First, Init.) | 2. Medicaid ID No. | 3. Birthdate | 4. Sex | 5. Address | Nursing Home ☐ Yes ☐ No | 6. Telephone (Area Code/Number)

7. Prescribing Physician/Practitioner Name And Address | 10. Provider Of Service(s) Name And Address

8. Medicaid Provider Number | 9. Telephone (Area Code/Number) | 11. Medicaid Provider Number | 12. Telephone (Area Code/Number)

☐ HOME HEALTH ☐ PODIATRIST ☐ OPTOMETRIST ☐ PHYSICIAN ☐ PSYCHOLOGIST ☐ DME/OP ☐ DDS ☐ PHARMACY

DEPT. USE ONLY

13. Authorization Period: From ___ Through ___ | 14. Description Of Service(s) Requested | 15. Rec. Type | 16. Qty. Of Svc.

17. Primary Diagnosis Requiring Service(s) | 18. ICD-9-CM

19. Justification And Circumstances For Required Service(s) (Use separate page if necessary)

STATEMENT OF SERVICE(S)

LINE NO. 20	21. Description Of Procedures, Drugs, Equipment, Or Other Services	22. Procedure/ Drug Code	23. Requested Or Estimated Price Per Unit	24. Bill Units	25. Months or Units Of Service	26. Units Per Claim Max.	26. Units Per Claim Min.	27. Max. Units Per Month
1								
2								
3								
4								
5								
6								
7								
8								

28. PROVIDER'S SIGNATURE

29. DATE SUBMITTED

30. REQUEST: ☐ APPROVED ☐ DENIED ☐ PENDING/ADDITIONAL INFORMATION ☐ APPROVED AS AMENDED

31. DMA SIGNATURE

32. DATE APPROVED

33. Explanation to Provider

*Prior authorization is contingent on patient eligibility and provider's enrollment in the Medicaid Program.

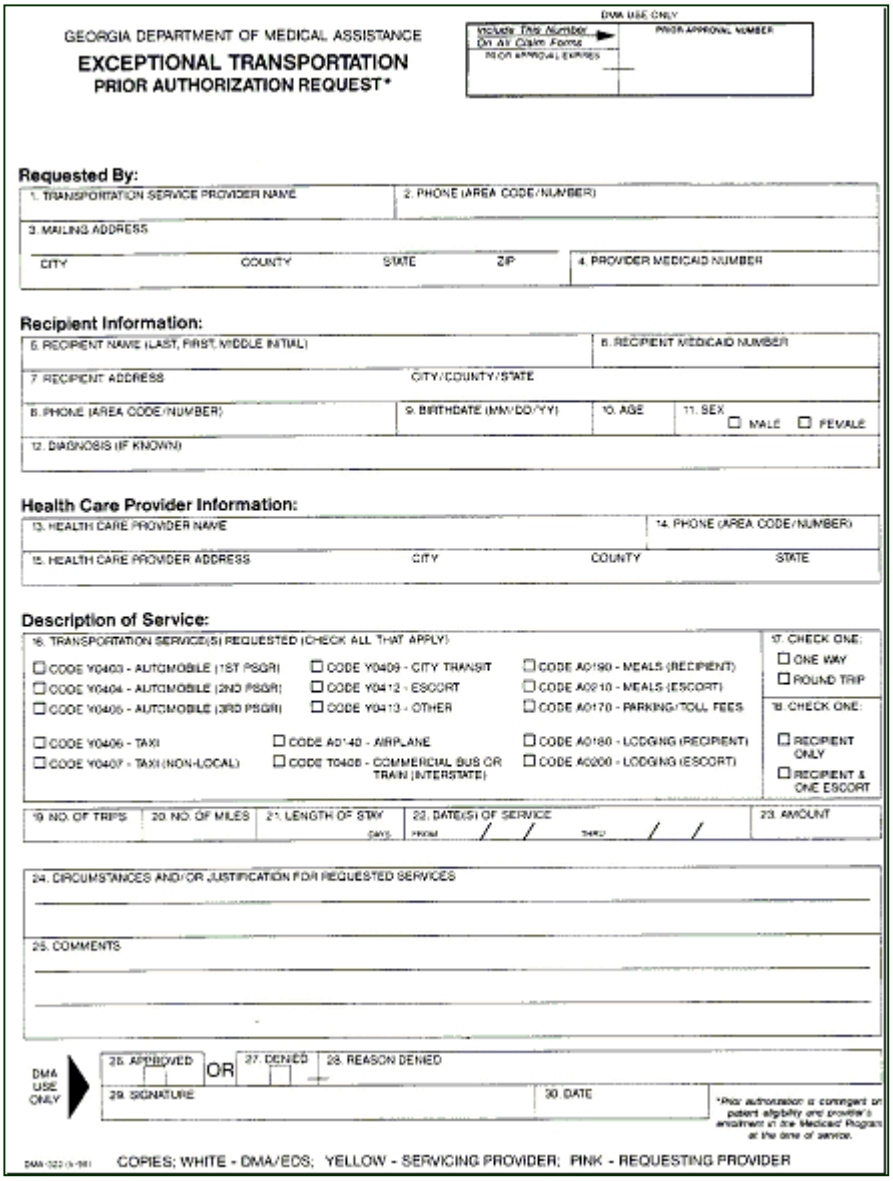
DMA-80 (3/03) COPIES: WHITE: DMA; PINK: SERVICING PROVIDER; GREEN: RECIPIENT'S FILE; YELLOW: REQUESTING PROVIDER

PROOF

Figure 6-1. Prior Authorization Form (DMA-80)

6.2 Exceptional Transportation Prior Authorization Request Form (DMA-322)

This process is available on the web, attachment free in most instances.



GEORGIA DEPARTMENT OF MEDICAL ASSISTANCE

EXCEPTIONAL TRANSPORTATION PRIOR AUTHORIZATION REQUEST*

DMA USE ONLY

Include This Number On All Claim Forms

PRIOR APPROVAL NUMBER

PRIOR APPROVAL EXPIRES

Requested By:

1. TRANSPORTATION SERVICE PROVIDER NAME | 2. PHONE (AREA CODE/NUMBER)

3. MAILING ADDRESS

CITY | COUNTY | STATE | ZIP | 4. PROVIDER MEDICAID NUMBER

Recipient Information:

5. RECIPIENT NAME (LAST, FIRST, MIDDLE INITIAL) | 6. RECIPIENT MEDICAID NUMBER

7. RECIPIENT ADDRESS | CITY/COUNTY/STATE

8. PHONE (AREA CODE/NUMBER) | 9. BIRTHDATE (MM/DD/YY) | 10. AGE | 11. SEX ☐ MALE ☐ FEMALE

12. DIAGNOSIS (IF KNOWN)

Health Care Provider Information:

13. HEALTH CARE PROVIDER NAME | 14. PHONE (AREA CODE/NUMBER)

15. HEALTH CARE PROVIDER ADDRESS | CITY | COUNTY | STATE

Description of Service:

16. TRANSPORTATION SERVICE(S) REQUESTED (CHECK ALL THAT APPLY)

☐ CODE Y0403 - AUTOMOBILE (1ST PSGR)
☐ CODE Y0404 - AUTOMOBILE (2ND PSGR)
☐ CODE Y0405 - AUTOMOBILE (3RD PSGR)
☐ CODE Y0406 - TAXI
☐ CODE Y0407 - TAXI (NON-LOCAL)
☐ CODE Y0409 - CITY TRANSIT
☐ CODE Y0412 - ESCORT
☐ CODE Y0413 - OTHER
☐ CODE A0140 - AIRPLANE
☐ CODE T0408 - COMMERCIAL BUS OR TRAIN (INTERSTATE)
☐ CODE A0190 - MEALS (RECIPIENT)
☐ CODE A0210 - MEALS (ESCORT)
☐ CODE A0170 - PARKING/TOLL FEES
☐ CODE A0180 - LODGING (RECIPIENT)
☐ CODE A0200 - LODGING (ESCORT)

17. CHECK ONE: ☐ ONE WAY ☐ ROUND TRIP

18. CHECK ONE: ☐ RECIPIENT ONLY ☐ RECIPIENT & ONE ESCORT

19. NO. OF TRIPS | 20. NO. OF MILES | 21. LENGTH OF STAY (DAYS) | 22. DATE(S) OF SERVICE (FROM / / THRU / /) | 23. AMOUNT

24. CIRCUMSTANCES AND/OR JUSTIFICATION FOR REQUESTED SERVICES

25. COMMENTS

DMA USE ONLY

26. APPROVED | OR | 27. DENIED | 28. REASON DENIED

29. SIGNATURE | 30. DATE

*Prior authorization is contingent on patient eligibility and provider's enrollment in the Medicaid Program at the time of service.

DMA-322 (3-98) COPIES: WHITE - DMA/ECS; YELLOW - SERVICING PROVIDER; PINK - REQUESTING PROVIDER

Figure 6-2. Exceptional Transportation Prior Authorization Request Form (DMA-322)

The DCH guidelines set forth in the Policies and Procedures Manual, Part I, Section 203 and Part II, Chapter 800, of the Policies and Procedures for Exceptional Transportation Services manual discusses prior approval procedures. (DCH identifies services requiring prior approval.)

The following tables explain the different sections on the DMA-322 form. Each table displays the field name and a brief description.

6.2.1 Exceptional Transportation Prior Authorization Request Form Field Descriptions

The following field descriptions are displayed on the DMA-322 forms. The field descriptions are displayed by sections.

Table 6-1. DMA-322 Field Descriptions

Requested By Section		
Form Locator	Field Name	Description
1.	Transportation Service Provider Name	Enter the name of the service provider (such as Greene County DFCS).
2.	Phone	Enter the provider's telephone number, including area code.
3.	Provider Address	Enter the provider's complete address, including county and zip code.
4.	Provider Medicaid Number	Enter the provider's Medicaid number.
Recipient Information Section		
5.	Recipient Name	Enter the member's name exactly as it appears on the member's current Medical Assistance Eligibility Certification.
6.	Recipient Medicaid Number	Enter the member's Medicaid Number exactly as it appears on the member's current Medical Assistance Eligibility Certification.
7.	Recipient's Address	Enter the member's complete address including zip code.
8.	Phone	Enter the member's telephone number, including the area code (if known).
9.	Birth date	Enter the member's birth date by month, day, year (MM/DD/YY format).
10.	Age	Enter the member's age on the date service is to be rendered.
11.	Sex	Check the appropriate box.
12.	Diagnosis (if known)	Enter the member's diagnosis(es), if known.
Health Care Provider Information Section		
13.	Health Care Provider Name	Enter the name of the health care provider (e.g., Dr. Mortimer N. Pestle; Towns Pharmacy; Memorial Hospital; etc.).
14.	Phone (Area Code/Number)	Enter the health care provider's telephone number, including area code (if known).
15.	Health Care Provider Address	Enter the health care provider's complete address.
Description of Service Section		
16.	Transportation Service Request	Check the appropriate box(es) to indicate the service(s) for which prior approval is being requested. Check all that apply.
17.	Check one	Check here to denote One Way Trip or Round Trip.
18	Check one	Check here to denote Member Only or Member and One Escort.
19.	Number of Trips	Enter the number of trips for which prior approval is requested.
20.	Number of Miles	Enter the number of miles (when applicable).
21.	Length of Stay	Enter the number of days (when applicable).
22.	Date(s) of Service	Enter the beginning and ending date(s) of service.
23.	Amount (used only with procedure code Y0413)	Enter the dollar amount for which prior approval is requested. The dollar amount should be explained in Item 25, especially when the request is for several services.
24.	Circumstances and/or Justification for Requested Services	Give the reason(s) for the transportation request such as the member's physical complaint, mental or emotional state, specific medical care, treatment or condition which necessitates the mode of service requested.
25.	Comments	Enter comments that may further explain the request, a breakdown explaining the dollar amount requested, and the name of the volunteer, airline, bus company, and so forth.

The Division of Medical Assistance (DMA), as appropriate, completes these items.

DMA Use Only		
Form Locator	Field Name	Description
26.	Approved	Marked with an "X" if the requested service is approved.
27.	Denied	Marked with an "X" if the requested service is denied.
28.	Reason Denied	Give the reason for the denial.
29.	Signature	The individual who approves or denies the prior authorization request must sign his or her name.
30.	Date	The date approval is granted or denied.

6.2.2 Prior Approval Request

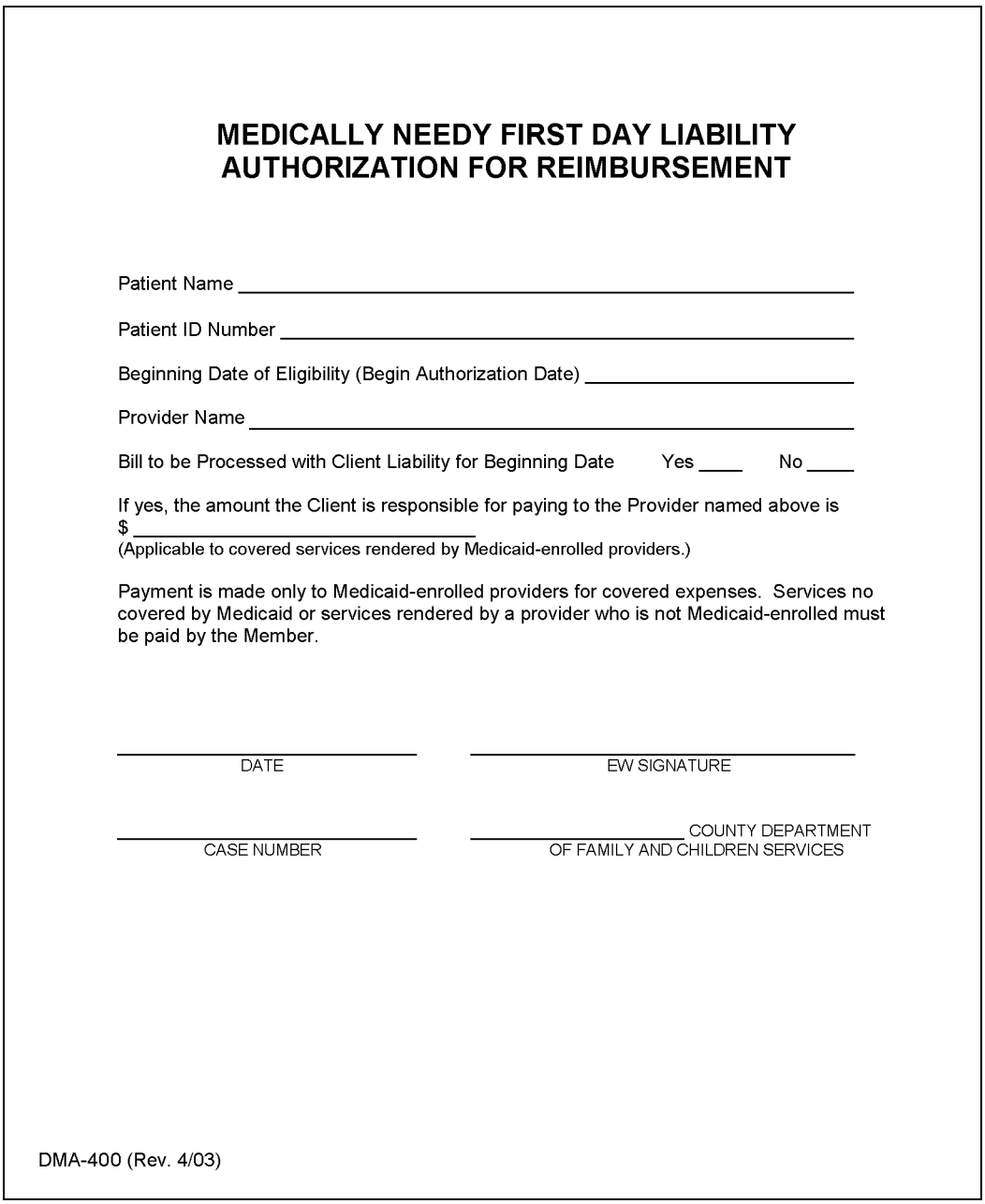
When prior approval is requested, the coordinator of transportation services for DFCS or the non-emergency ambulance service provider must complete the Exceptional Transportation Prior Authorization Form, DMA-322, and submit all copies to GHP. The mailing address is:

GHP
P. O. Box 7000
McRae, GA 31055

This process is available on the web, attachment free in most instances.

6.3 Medically Needy Spenddown Form (DMA-400)

The DMA-400 form is completed by DFCS for services rendered to medically needy members on the same date as the beginning date of eligibility. The form identifies the spenddown amount of first day liability which is payable to the provider by the member.



MEDICALLY NEEDY FIRST DAY LIABILITY
AUTHORIZATION FOR REIMBURSEMENT

Patient Name _____

Patient ID Number _____

Beginning Date of Eligibility (Begin Authorization Date) _____

Provider Name _____

Bill to be Processed with Client Liability for Beginning Date Yes ____ No ____

If yes, the amount the Client is responsible for paying to the Provider named above is
$ _____
(Applicable to covered services rendered by Medicaid-enrolled providers.)

Payment is made only to Medicaid-enrolled providers for covered expenses. Services no covered by Medicaid or services rendered by a provider who is not Medicaid-enrolled must be paid by the Member.

_____ _____
DATE EW SIGNATURE

_____ _____ COUNTY DEPARTMENT
CASE NUMBER OF FAMILY AND CHILDREN SERVICES

DMA-400 (Rev. 4/03)

Figure 6-3. Medically Needy Spenddown Form (DMA-400)

6.3.1 What is the Medically Needy Spenddown Program?

The Medically Needy program covers children under age eighteen, pregnant women, aged, blind and disabled persons who otherwise are not Medicaid eligible because of income. Their monthly income may exceed the Medicaid payment income eligibility standard and would result in these individuals having to pay for a prescribed amount of their healthcare before they are eligible for Medicaid.

DMA-964 Form: Certification of Medicaid Eligibility

An individual determined eligible for the Medically Needy Spenddown program by the county DFCS office is issued a DMA-964 Form (Certification of Medicaid Eligibility) for the first partial month of eligibility and DMA-400 Form(s) (Medically Needy First Day Liability Authorization for Reimbursement) for the first day of eligibility.

The DMA-964 form shows the Medicaid ID number and full name of each individual certified for Medicaid. The eligible individual is responsible for presenting the DMA-964 form to all medical providers who render services to the individual during the first month of eligibility. The DMA-964 form also shows the beginning date of eligibility and a statement in the remarks section to alert providers that the DMA-964 form may be necessary for payment of the medically needy claim.

If the statement on the DMA-964 form reads, "DMA Form 400 required" and if the beginning date of eligibility is equal to the DOS or within the span of dates of service, the DMA-400 form must be attached to the submitted claim for payment. If not attached, the claim is rejected or denied to the provider, with an error message stating that the DMA-400 form is required before the claim can be processed.

DMA-400 Form

The DMA-400 form is completed by DFCS for services rendered to Medically Needy Members on the same date as the beginning date of eligibility. The form identifies the spenddown amount of first day liability, which is payable to the provider by the member. This amount could be zero; however, the paper DMA-400 form must be submitted for payment.

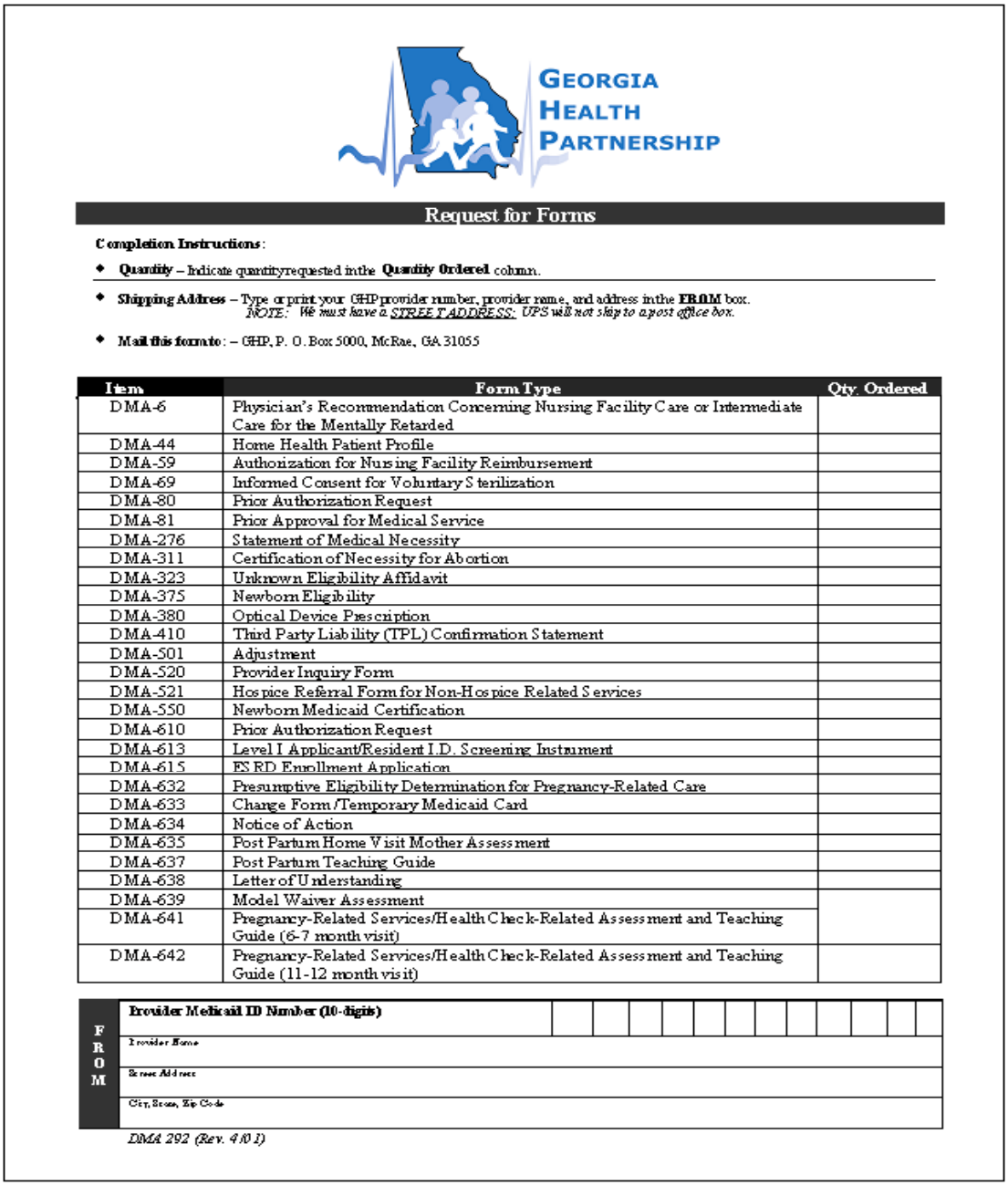
NOTE:
Do not deduct the first day liability amount that appears on Form 400 from submitted charges.

If you have any questions about eligibility or the DMA-400 form, contact the member or your county DFCS office.

6.4 Request for Forms (DMA-292)

The DMA-292 form is used to order forms from the Georgia Health Partnership. The items that can be ordered are shown in the **Item** column and a description of the form is shown in the **Form Type** column. In the **Qty. Ordered** field indicate the desired amount you would like shipped.

You can photocopy this form to order any form(s) that you may need. Or, call us and we will send the DMA-292 form to you.



GEORGIA HEALTH PARTNERSHIP

Request for Forms

Completion Instructions:

- **Quantity** – Indicate quantity requested in the **Quantity Ordered** column.
- **Shipping Address** – Type or print your GHP provider number, provider name, and address in the **FROM** box.
  NOTE: We must have a STREET ADDRESS. UPS will not ship to a post office box.
- **Mail this form to**: – GHP, P. O. Box 5000, McRae, GA 31055

Item	Form Type	Qty. Ordered
DMA-6	Physician's Recommendation Concerning Nursing Facility Care or Intermediate Care for the Mentally Retarded	
DMA-44	Home Health Patient Profile	
DMA-59	Authorization for Nursing Facility Reimbursement	
DMA-69	Informed Consent for Voluntary Sterilization	
DMA-80	Prior Authorization Request	
DMA-81	Prior Approval for Medical Service	
DMA-276	Statement of Medical Necessity	
DMA-311	Certification of Necessity for Abortion	
DMA-323	Unknown Eligibility Affidavit	
DMA-375	Newborn Eligibility	
DMA-380	Optical Device Prescription	
DMA-410	Third Party Liability (TPL) Confirmation Statement	
DMA-501	Adjustment	
DMA-520	Provider Inquiry Form	
DMA-521	Hospice Referral Form for Non-Hospice Related Services	
DMA-550	Newborn Medicaid Certification	
DMA-610	Prior Authorization Request	
DMA-613	Level I Applicant/Resident I.D. Screening Instrument	
DMA-615	ESRD Enrollment Application	
DMA-632	Presumptive Eligibility Determination for Pregnancy-Related Care	
DMA-633	Change Form /Temporary Medicaid Card	
DMA-634	Notice of Action	
DMA-635	Post Partum Home Visit Mother Assessment	
DMA-637	Post Partum Teaching Guide	
DMA-638	Letter of Understanding	
DMA-639	Model Waiver Assessment	
DMA-641	Pregnancy-Related Services/Health Check-Related Assessment and Teaching Guide (6-7 month visit)	
DMA-642	Pregnancy-Related Services/Health Check-Related Assessment and Teaching Guide (11-12 month visit)	

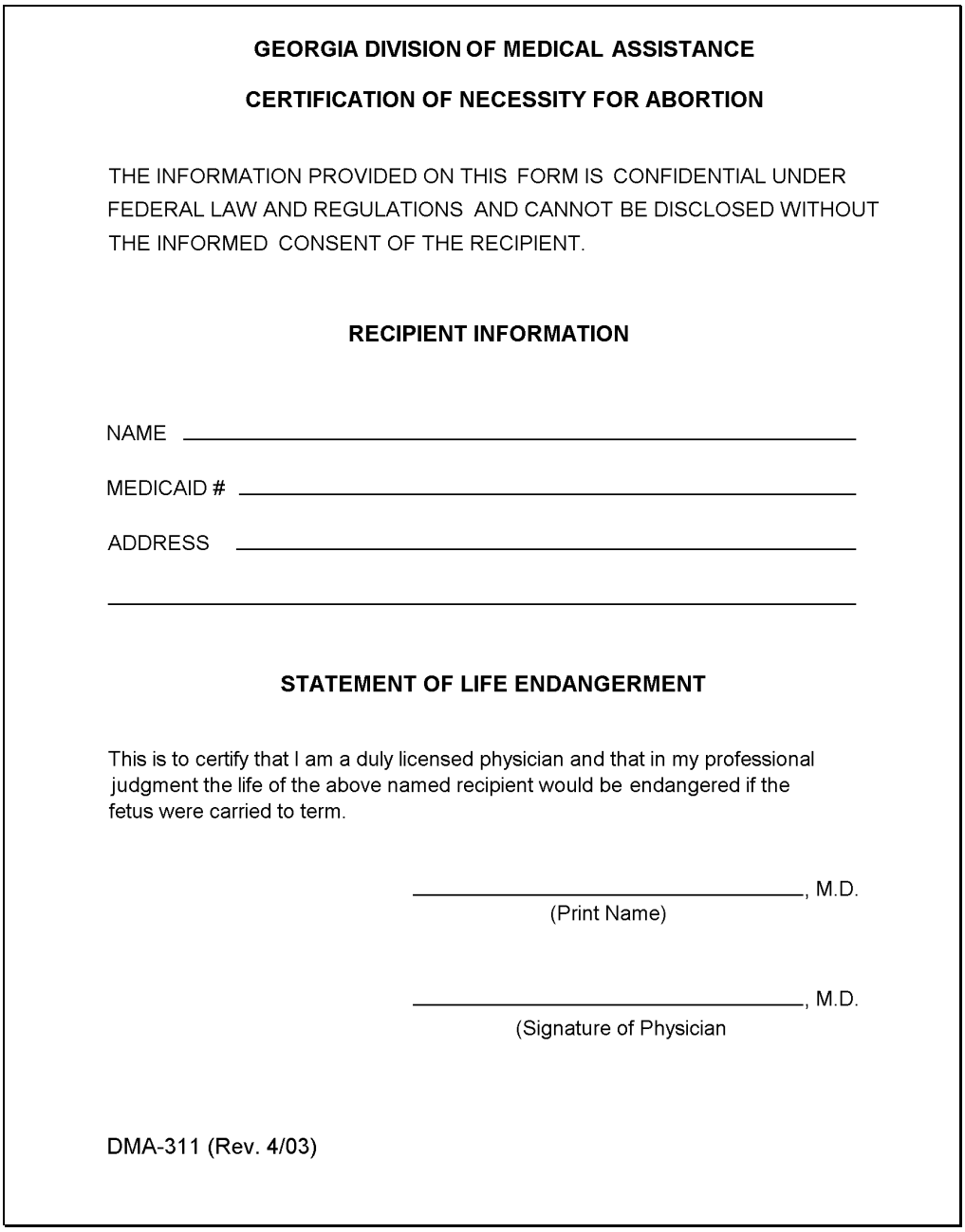
FROM		
	Provider Medicaid ID Number (10-digits)	
	Provider Name	
	Street Address	
	City, State, Zip Code	

DMA 292 (Rev. 4/01)

Figure 6-4. GHP Request for Forms (DMA-292)

6.5 Certification of Necessity for Abortion Form (DMA-311)

The Certification of Necessity for Abortion form is required when filing a claim for an abortion procedure and may be submitted online or as a hard copy.



GEORGIA DIVISION OF MEDICAL ASSISTANCE

CERTIFICATION OF NECESSITY FOR ABORTION

THE INFORMATION PROVIDED ON THIS FORM IS CONFIDENTIAL UNDER FEDERAL LAW AND REGULATIONS AND CANNOT BE DISCLOSED WITHOUT THE INFORMED CONSENT OF THE RECIPIENT.

RECIPIENT INFORMATION

NAME _____

MEDICAID # _____

ADDRESS _____

_____

STATEMENT OF LIFE ENDANGERMENT

This is to certify that I am a duly licensed physician and that in my professional judgment the life of the above named recipient would be endangered if the fetus were carried to term.

_____, M.D.
(Print Name)

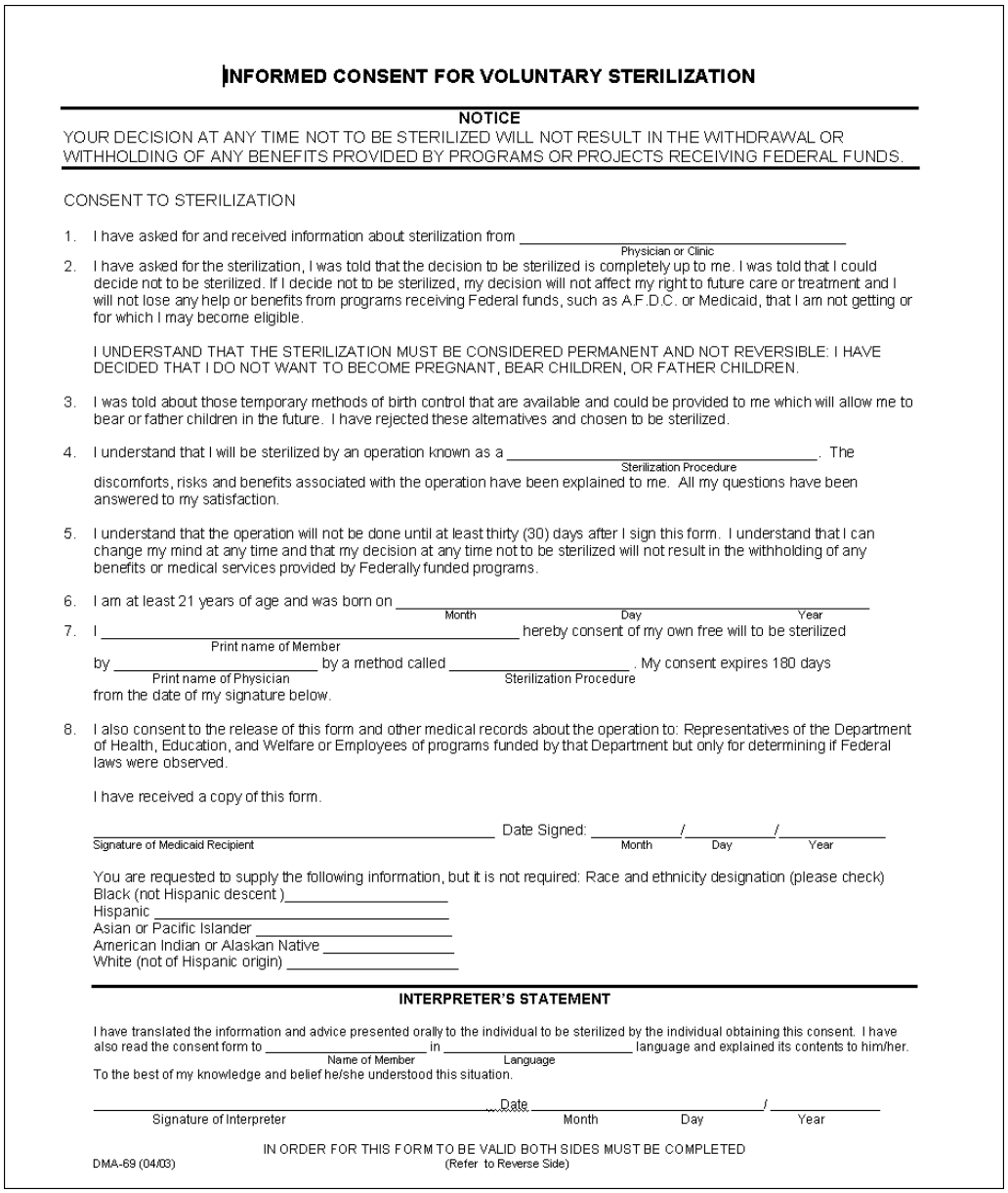
_____, M.D.
(Signature of Physician

DMA-311 (Rev. 4/03)

Figure 6-5. Certification of Necessity for Abortion Form (DMA-311)

6.6 Informed Consent for Voluntary Sterilization Form (DMA-69)

This form is required whenever submitting a claim for voluntary sterilization and may be submitted online or as a hard copy.



INFORMED CONSENT FOR VOLUNTARY STERILIZATION

NOTICE

YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

1. I have asked for and received information about sterilization from _____ (Physician or Clinic)
2. I have asked for the sterilization, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment and I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid, that I am not getting or for which I may become eligible.

   I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE: I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN, OR FATHER CHILDREN.
3. I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father children in the future. I have rejected these alternatives and chosen to be sterilized.
4. I understand that I will be sterilized by an operation known as a _____ (Sterilization Procedure). The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.
5. I understand that the operation will not be done until at least thirty (30) days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by Federally funded programs.
6. I am at least 21 years of age and was born on _____ (Month) _____ (Day) _____ (Year)
7. I _____ (Print name of Member) hereby consent of my own free will to be sterilized by _____ (Print name of Physician) by a method called _____ (Sterilization Procedure). My consent expires 180 days from the date of my signature below.
8. I also consent to the release of this form and other medical records about the operation to: Representatives of the Department of Health, Education, and Welfare or Employees of programs funded by that Department but only for determining if Federal laws were observed.

   I have received a copy of this form.

_____ (Signature of Medicaid Recipient) Date Signed: _____ (Month) /_____ (Day) /_____ (Year)

You are requested to supply the following information, but it is not required: Race and ethnicity designation (please check)
Black (not Hispanic descent)_____
Hispanic _____
Asian or Pacific Islander _____
American Indian or Alaskan Native _____
White (not of Hispanic origin) _____

INTERPRETER'S STATEMENT

I have translated the information and advice presented orally to the individual to be sterilized by the individual obtaining this consent. I have also read the consent form to _____ (Name of Member) in _____ (Language) language and explained its contents to him/her.
To the best of my knowledge and belief he/she understood this situation.

_____ (Signature of Interpreter) Date _____ (Month) /_____ (Day) /_____ (Year)

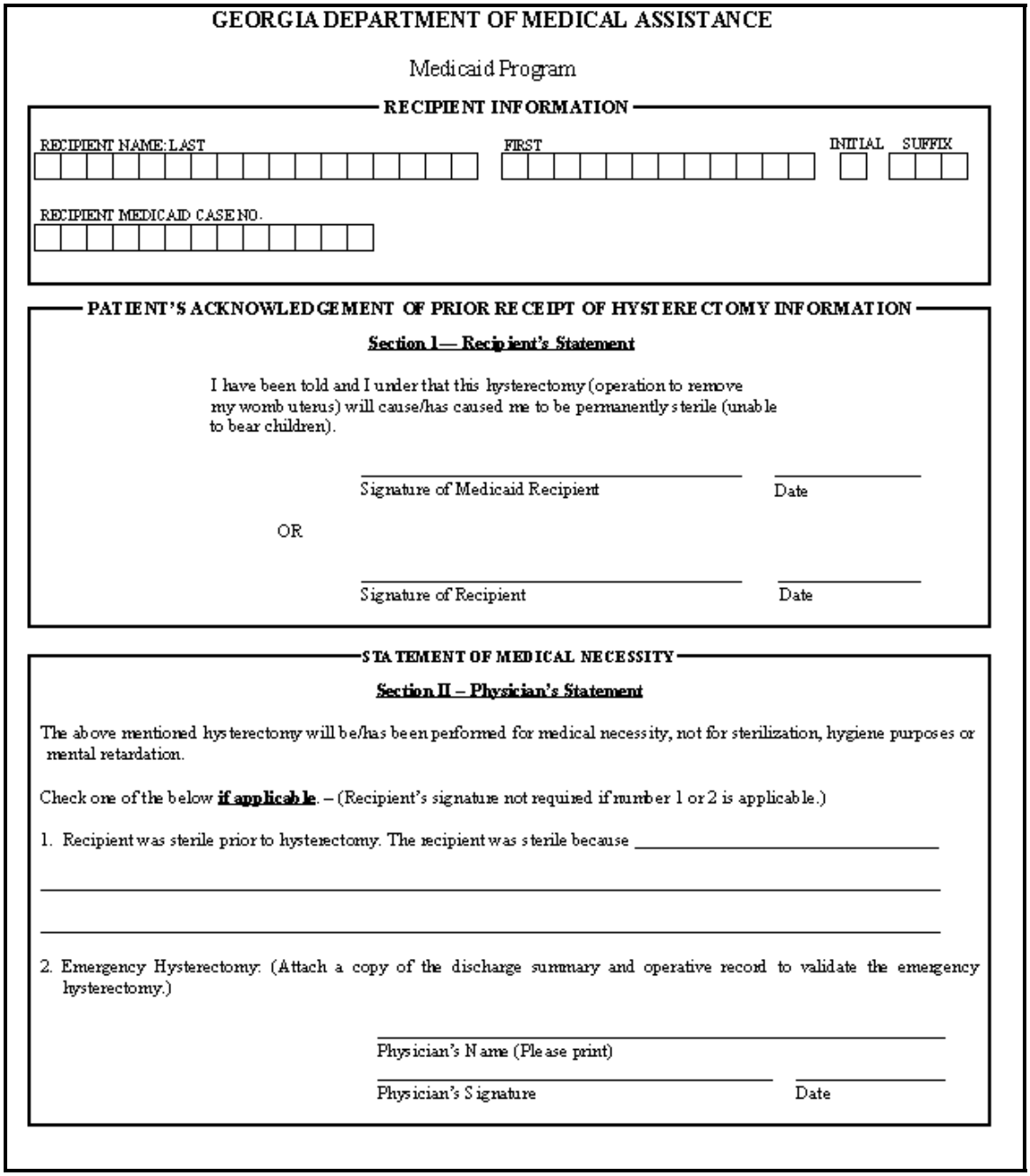
IN ORDER FOR THIS FORM TO BE VALID BOTH SIDES MUST BE COMPLETED

DMA-69 (04/03) (Refer to Reverse Side)

Figure 6-6. Informed Consent for Voluntary Sterilization Form (DMA-69)

6.7 Acknowledgement of Prior Receipt of Hysterectomy Information Form (DMA-276)

This form is required for every hysterectomy procedure and may be submitted online or as a hard copy.



GEORGIA DEPARTMENT OF MEDICAL ASSISTANCE

Medicaid Program

RECIPIENT INFORMATION

RECIPIENT NAME: LAST | FIRST | INITIAL | SUFFIX

RECIPIENT MEDICAID CASE NO.

PATIENT'S ACKNOWLEDGEMENT OF PRIOR RECEIPT OF HYSTERECTOMY INFORMATION

Section I — Recipient's Statement

I have been told and I under that this hysterectomy (operation to remove my womb uterus) will cause/has caused me to be permanently sterile (unable to bear children).

Signature of Medicaid Recipient — Date

OR

Signature of Recipient — Date

STATEMENT OF MEDICAL NECESSITY

Section II – Physician's Statement

The above mentioned hysterectomy will be/has been performed for medical necessity, not for sterilization, hygiene purposes or mental retardation.

Check one of the below **if applicable**. – (Recipient's signature not required if number 1 or 2 is applicable.)

1. Recipient was sterile prior to hysterectomy. The recipient was sterile because _____

2. Emergency Hysterectomy: (Attach a copy of the discharge summary and operative record to validate the emergency hysterectomy.)

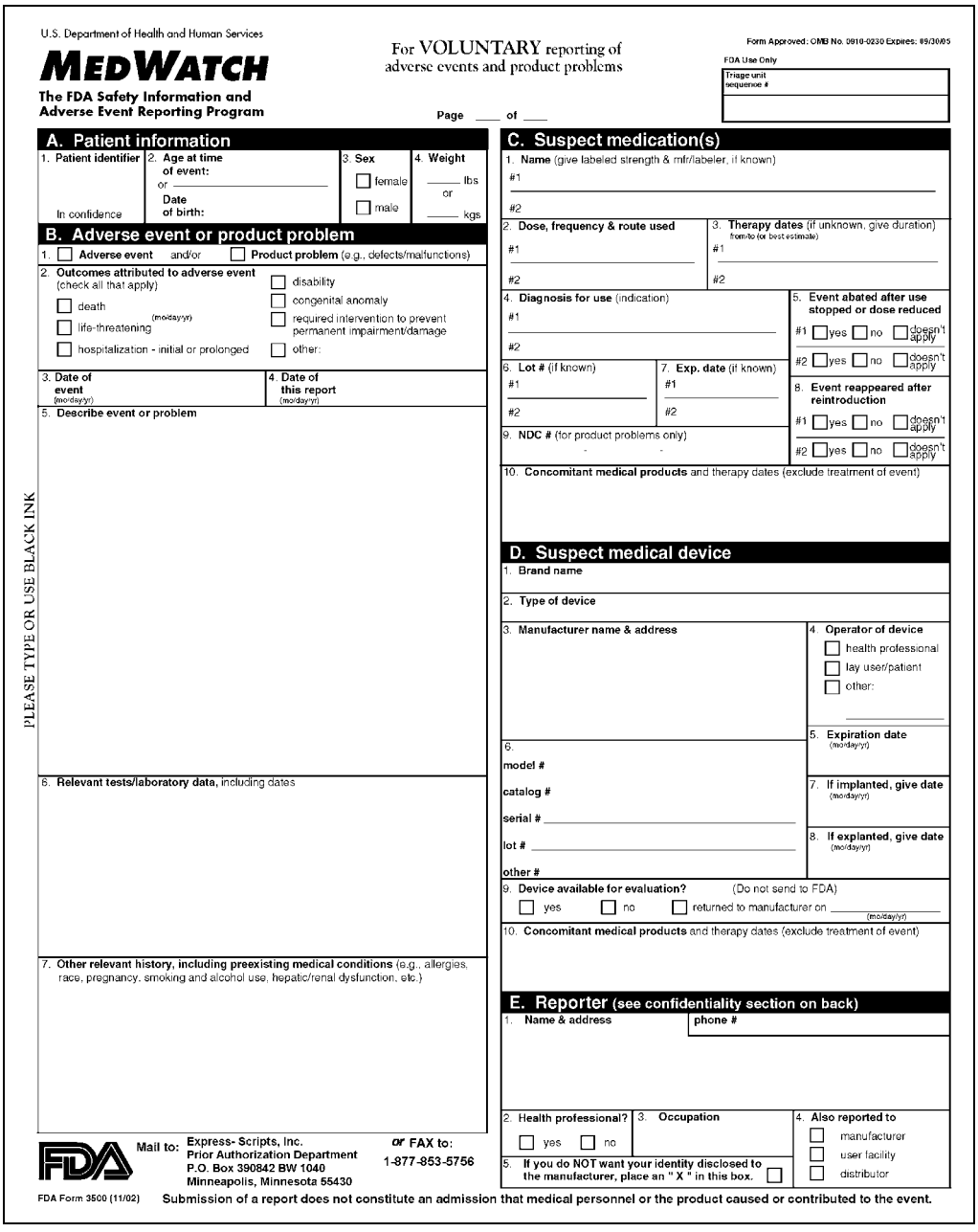
Physician's Name (Please print)

Physician's Signature — Date

Figure 6-7. Acknowledgement of Prior Receipt of Hysterectomy Information Form (DMA-276)

6.8 MedWatch Form

The following is an example of the MedWatch form. You can use this form to report adverse events and problems with prescription drugs.



U.S. Department of Health and Human Services

MEDWATCH

The FDA Safety Information and Adverse Event Reporting Program

For VOLUNTARY reporting of adverse events and product problems

Form Approved: OMB No. 0910-0230 Expires: 09/30/05

FDA Use Only

Triage unit sequence #

Page ____ of ____

PLEASE TYPE OR USE BLACK INK

A. Patient information

1. Patient identifier — In confidence
2. Age at time of event: or Date of birth:
3. Sex — ☐ female ☐ male
4. Weight — ____ lbs or ____ kgs

B. Adverse event or product problem

1. ☐ Adverse event and/or ☐ Product problem (e.g., defects/malfunctions)
2. Outcomes attributed to adverse event (check all that apply)
   - ☐ death
   - ☐ life-threatening (mo/day/yr)
   - ☐ hospitalization - initial or prolonged
   - ☐ disability
   - ☐ congenital anomaly
   - ☐ required intervention to prevent permanent impairment/damage
   - ☐ other:
3. Date of event (mo/day/yr)
4. Date of this report (mo/day/yr)
5. Describe event or problem
6. Relevant tests/laboratory data, including dates
7. Other relevant history, including preexisting medical conditions (e.g., allergies, race, pregnancy, smoking and alcohol use, hepatic/renal dysfunction, etc.)

C. Suspect medication(s)

1. Name (give labeled strength & mfr/labeler, if known) #1 #2
2. Dose, frequency & route used #1 #2
3. Therapy dates (if unknown, give duration) from-to (or best estimate) #1 #2
4. Diagnosis for use (indication) #1 #2
5. Event abated after use stopped or dose reduced #1 ☐ yes ☐ no ☐ doesn't apply #2 ☐ yes ☐ no ☐ doesn't apply
6. Lot # (if known) #1 #2
7. Exp. date (if known) #1 #2
8. Event reappeared after reintroduction #1 ☐ yes ☐ no ☐ doesn't apply #2 ☐ yes ☐ no ☐ doesn't apply
9. NDC # (for product problems only) - -
10. Concomitant medical products and therapy dates (exclude treatment of event)

D. Suspect medical device

1. Brand name
2. Type of device
3. Manufacturer name & address
4. Operator of device ☐ health professional ☐ lay user/patient ☐ other:
5. Expiration date (mo/day/yr)
6. model # catalog # serial # lot # other #
7. If implanted, give date (mo/day/yr)
8. If explanted, give date (mo/day/yr)
9. Device available for evaluation? (Do not send to FDA) ☐ yes ☐ no ☐ returned to manufacturer on ____ (mo/day/yr)
10. Concomitant medical products and therapy dates (exclude treatment of event)

E. Reporter (see confidentiality section on back)

1. Name & address — phone #
2. Health professional? ☐ yes ☐ no
3. Occupation
4. Also reported to ☐ manufacturer ☐ user facility ☐ distributor
5. If you do NOT want your identity disclosed to the manufacturer, place an " X " in this box. ☐

Mail to: Express- Scripts, Inc. Prior Authorization Department P.O. Box 390842 BW 1040 Minneapolis, Minnesota 55430

or FAX to: 1-877-853-5756

FDA Form 3500 (11/02)

Submission of a report does not constitute an admission that medical personnel or the product caused or contributed to the event.

Figure 6-8. MedWatch Form

6.9 Durable Medical Equipment Regional Carrier Form

Following is an example of the Durable Medical Equipment Regional Carrier form.

Effective 10/01/00

DMERC 08.02

DMERC Information Form: IMMUNOSUPPRESSIVE DRUGS

ALL INFORMATION ON THIS FORM MAY BE COMPLETED BY THE SUPPLIER

Certification Type/date: INITIAL ___/____/____ REVISED ___/____/____

PATIENT NAME, ADDRESS, TELEPHONE AND HIC NUMBER	SUPPLIER NAME, ADDRESS, TELPHONE AND NSC NUMBER
( )_____HICN_____	( )_____NSC_____
PLACE OF SERVICE_____ NAME and ADDRESS OF FACILITY if applicable (see reverse):	PT DOB ____/____/____ Sex _____(M/F)

TRANSPLANT DIAGNOSIS CODES (ICD-9_ (CIRCLE APPROPRIATE CODES): V42.1 (HEART) V42.7 (LIVER) V42.0 (KIDNEY); V42.5 (LUNG); V42.8 (DONE MARROW V42.8 (OTHER-SPECIFY) (_____)

ANSWERS	ANSWER QUESTIONS 1-5 AND 8-12 FOR IMMUNOSUPPRESSIVE DRUGS (Circle Y for Yes, N for No, or D for Does Not Apply, Unless Otherwise Noted)
	Questions 6 and 7, reserved for other or future use.
	What are the drug(s) prescribed and the dosage and frequency of administration of each? HCPCS MG ES PER DAY 1. _____ _____ _____ 2. _____ _____ _____ 3. _____ _____ _____
Y N	4. Has the patient had a organ transplant that was covered by Medicare?
Enter Correct Number(s) _____ _____ _____	5. Which organ(s) have been transplanted? (list most recent transplant) (May enter up to three different organs). 1-Heart 2-Liver 3-Kidney 4-Bone Marrow 5-Lung 6-whole organ pancreas, simultaneous with or subsequent to a kidney transplant 7-Reserved future use 8-Reserved future use 9-Other
_____	8. Name of facility where transplant was performed.
_____	9. City where facility is located.
_____	10. State where facility is located
___/___/___	11. on what date was the patient discharged from the hospital following this transplant surgery?
Y N	12. Was there a prior transplant failure of this same organ?

PHYSICIAN NAME, ADDRESS (Printed or Typed)	
UPIN:_____ TELEPHONE #: (____)_____	_____ _____/_____/_____ SUPPLIER'S SIGNATURE DATE (A Stamped Signature is Not Acceptable) _____ PRINT NAME

Rev. 07/13/2000

Figure 6-9. Durable Medical Equipment Regional Carrier (DMERC) Information Form

7. Coordination of Benefits/Medicaid Secondary Payer

This chapter includes these COB/Medicaid Secondary Payer topics:

7.1 Filing Medicaid Secondary Claims

Medicaid is the payor of last resort. In cases where members have a separate health benefit plan, the provider must attempt to exhaust all third party benefits prior to submitting a claim to DCH. Claims with private insurance must be submitted to Medicaid within 12 months from the date of service.

7.1.1 Paper Claims

You can bill a paper claim by completing the claim form (CMS-1500, UB-92, or ADA) and attaching the required documentation, such as the primary insurance's Explanation of Benefits (EOB) denial, a denial letter, or the COB Statement and Notification form.

Paper claims (all types) should be submitted to the address below. Although paper claims will continue to be accepted, providers are strongly encouraged to submit claims electronically.

GHP
P.O. Box 5000
McRae, GA 31055-5000

Remember: There are other methods of filing claims (e. g., via the web portal, WINASAP2000).

NOTE:
Georgia-specific claim forms are no longer accepted.

7.1.2 WINASAP2000

WINASAP2000 Claims Submission is a free software package from ACS EDI Gateway, Incorporated. It is an easy-to-use Windows-based application that replaces the old DOS-based Electronic Media Claim (EMC) software. You may order a copy of WINASAP2000 by calling (800) 987-6715 (Monday – Friday, 8:00 a.m. – 5:00 p.m. EST) or by visiting *http://www.acs-gcro.com*. (The WINASAP 2000 software will be modified in the fall of 2003 to eliminate the need for most paper documentation.)

You do not need Internet access to use WINASAP2000. If you have a computer, a telephone line, and a modem, you can use WINASAP 2000.

During the period from April 1, 2003 until the format is updated, special rules apply if you use the WINASAP2000 software or a clearinghouse vendor. To use these two methods for filing electronic

claims during this time, in many instances you must also submit the appropriate paper attachment after you submit the electronic claim as if the electronic claim were a paper claim. You must write the associated claim's TCN on the top of the attachment so that the electronic claim and the attachment can be re-associated for processing.

7.1.3 Clearinghouse Vendor

If you use a clearinghouse or billing agent, the company must be able to submit an X12N (837) transaction on your behalf. (The X12 submissions will not require paper attachments except in certain cases, such as abortion, hysterectomies and sterilization.)

- A clearinghouse is a company that accepts claims from you (the provider) and routes them to fiscal agents and other payers. The clearinghouse may also take responsibility for translating claims into formats that payers require.

- A billing agent is a company that acts as a third party to providers, actually billing or entering the electronic claims on your behalf.

- Most clearinghouse vendors will not be HIPAA compliant until required to do so in October, 2003. All EDI (EMC) claims have been set to suspend for 30 days to allow time for providers to mail in or fax in the appropriate COB documentation.

7.1.4 Web Portal

You can also submit claims one at a time by entering them directly into the web portal. The web portal also provides access to submit batch claims in X12N (837) formats. However, batch submissions require a practice management system to create the batch file.

Regardless of the method of submission, claims may be adjusted, edited and resubmitted, and voided through the web portal (see the chart below). For example, if you submit a claim through a clearinghouse, you are able to adjust, edit and resubmit, and void it through the web portal.

Table 7-1. Web Portal Availability

WINASAP2000	Available 24 hours after submission
Web-Individual	Available immediately after submission
Web-Batch	Available 4 hours after submission
Clearinghouse	Available 4 hours after submission if submitted through the web, and 24 hours after submission is submitted directly to EDI

NOTE:
In order to adjust any claim (regardless of the transmission method), you must have the assigned transaction control number (TCN).

The GHP Web Portal address is *http://www.ghp.georgia.gov*. For additional assistance with claims submission via the web portal, call the Provider Inquiry Unit at (404) 298-1228 (Metro Atlanta) or (800) 766-4456 (toll free).

7.2 Coordination of Benefits/Medicaid Secondary Billing Tips

You can bill electronically using WINASAP2000, the web portal, or your clearinghouse vendor. You can also bill using the 837P, 837D, or 837I format without a clearinghouse (through the Electronic Data Interchange).

You can bill a hard copy claim using a CMS-1500, UB-92, or ADA claim form. Use the appropriate field to indicate the amount paid by the primary insurance. Indicate the carrier number or carrier name and address in the appropriate block of the claim form. Also, indicate the total amount paid, including any discounts, in the appropriate block of the claim form (form locator 29.)

No attachments are necessary unless a member has two or more insurance policies or the claim was denied by the primary insurance. Attach copies of the Explanation of Benefits (EOB) for each policy to the back of your claim for processing. If submitting the claim electronically, you may submit the paper attachment to PO Box 5000; McRae, GA 31055-5000. You can also fax it to 1-866-483-1044.

Follow these billing tips to speed the processing of your claim:

- Verify Medicaid eligibility, including verification of Medicaid known primary insurance plans, each time service is requested. See Chapter 3, Member Eligibility, for eligibility verification details.

- In most cases, you must bill the primary insurance plans first, and then bill Medicaid. If more than one health plan exists for that member, you must bill all available plans before billing Medicaid. The following are exceptions to this requirement:

    - Non-institutional pregnancy related claims

    - Health Check claims

    - Coverage provided by a parent due to Absent Parent Court Ordered Medical Support

      In these cases, you have the option to bill the primary insurance plans first, and then bill Medicaid, or bill Medicaid only. If you choose to bill Medicaid rather than to bill the primary plans, you can never bill the primary plan for those services. Medicaid reimburses you the full Medicaid allowance and then seeks reimbursement directly from the primary plans.

- Do not use a highlighter on claim forms or other documents. All claims are imaged, and highlighted areas are darkened and illegible when claim copies are retrieved for review.

- Write “COB” in bold letters on all attachments.

- If you use electronic billing and you need to send a separate paper attachment, remember that you must write the associated claim TCN at the top of the form.

- Enter *only* third party payments in the “Amount Paid” block (form locator 29) of the claim form. Medicaid-required copayments are not entered in form locator 29 of the CMS-1500 claim form

7.3 Common Coordination of Benefits Questions

Providers sometimes have questions about filing and billing COB claims. The most common questions are answered below:

Question 1: **When do I file a Medicaid Secondary payer claim for a Medicaid member?**

Answer:

The enrolled provider must make reasonable efforts to collect funds from all liable third parties. Reasonable efforts include, but are not limited to:

- Reviewing member eligibility each month.
- Questioning the member to identify the presence of a primary insurance.
- Filing claim(s) with the appropriate third parties, prior to filing with Medicaid.
- Reporting any identified primary insurance plans and indicating the paid amounts in the appropriate fields, whether billing a paper claim or electronically.
- Contacting the primary insurance for a verbal determination.

Question 2: If I don't receive third party payment, how do I bill Medicaid?

Answer:

- You can bill electronically using WINASAP2000, the web portal. However, you should note that during the period from April 1, 2003 until the format is updated in the Fall of 2003, special rules apply if you use the WINASAP2000 software or a clearinghouse vendor. To use this method, you must also submit the appropriate paper attachment after you submit the electronic claim. You must write the associated claim's TCN on the top of the attachment so that the electronic claim and the attachment can be re-associated for processing.
- You can bill a paper claim by completing the claim form (CMS-1500, UB-92, or ADA) and attaching the required documentation, such as the primary insurance's EOB denial, a denial letter, or the COB Confirmation and Notification Statement.
- **Remember the filing deadlines.** If you don't receive a response from the primary insurance and you are nearing the COB timely filing limit of 12 months from the date of service, follow these steps:

    1) Complete the COB Notification Form.
    2) Explain that you received no response from the primary insurance.
    3) Submit the COB Notification Form with your paper claim or submit it separately (marked with the associated TCN) following an electronic claim submission.

Question 3: How long do I have to file my Medicaid Secondary claim to Medicaid?

Answer:

- When eligible members have other insurance coverage, you have up to one year from the date of service (DOS) to send your claim to GHP for payment.

- Please refer to Part I Policy, Section 201.3(b), for more detailed information on timely submission of claims.

Question 4: How do I bill a Health Maintenance Organization (HMO) copayment?

Answer:

- Bill only if you are an "in-network" provider for the member's prepaid managed care plan.

- If no Explanation of Benefits (EOB) is available, attach the COB Notification Form indicating the copayment amount in the appropriate field.

- You can only bill an amount equal to the member's copayment amount in any field designated as 'Billed Amount', '$ Charges', or 'Total Charges.'

7.4 Coordination of Benefits Confirmation and Notification Form

Consider this example of how a COB Confirmation and Notification Statement is used:

Scenario: The provider discovers that the member's COB information is no longer valid. The provider reports the new information in the COB Non-Coverage Affidavit section of the form. The member is using a new insurance carrier, so the provider reports this information in the COB Notification section. The new insurance is an HMO and no EOB is available. When billing for the copayment, the provider writes the insurance carrier name and copayment in the box below the member's name.

The COB Notification Form can perform up to three functions at once:

- Confirm that no response was received from the member's insurance carrier.
- Notify and provide details to DCH regarding a member's primary insurance.
- Allow copayment billing when there is no EOB available.

7.4.1 Tips for Completing the Coordination of Benefits and Notification Form

Follow these tips when completing a COB and Notification Form:

- Make sure the form is signed and dated.
- Enter the provider's number in the space provided.
- Enter the provider's category of service on the line in front of "Services."
- Complete separate forms for each insurance card, if the member uses multiple cards, such as a medical card and a pharmacy card.

7.4.2 Coordination of Benefits Notification Form (DMA-410)

The following is an example of the COB Notification Form.

TCN

COB NOTIFICATION FORM

Recipient Name: _____ **Medicaid ID #:** _____

***I. TPL CONFIRMATION*:**

I submitted my claim(s) to _____ on _____
Insurance Carrier *Date*

for payment. After receiving no response, I contacted the carrier on _____ for confirmation.
Date

Insurance Representative: _____ Telephone #: _____

_____ Insurance was cancelled on _____
Date

_____ Service is non-covered; annual/lifetime service limits exceeded

_____ Recipient not covered under this policy

_____ Other _____

Attach this form to your claim(s) and forward both to ACS/COB for processing.

***II. TPL NOTIFICATION*:**

When completing only this portion of the form, it may be faxed to ACS/COB Unit at 404-298-1031 or mailed to ACS/COB Unit; If there are multiple cards, e.g., a medical card and a pharmacy card, complete separate forms or make copies of all cards (front & back), attach to this form and submit.

TPL INFORMATION: *Please complete in full or attach a copy of the insurance card(s), front and back.*

Policyholder: _____ **Pt. Relationship to Policyholder:** _____

Insurance Carrier: _____ **Policy #:** _____

Employer: _____ **Group #:** _____

Subscriber/Member ID #: _____ **Effective Date:** _____

Coverage Type(s): *(Circle All that apply)* **HMO PPO Major Medical Dental Vision**
Pharmacy Long Term Care Other:_____

By signing, I certify that, to the best of my knowledge, the information above is verified and accurate, and the confirmation statement applies to any attached claim and is made a part thereof.

_____ _____ _____
Signature of Patient Account Representative *Date* *Provider #*

Note: This statement must be in accordance with the provisions of Part I, Policies and Procedures, Chapter 200 - Timely Submission, Section 201.3(b).

THIS FORM MAY BE PHOTOCOPIED

DMA-410 (4-03)

Figure 7-1. Coordination of Benefits (COB) Confirmation Statement

7.4.3 Pharmacy-Specific Coordination of Benefits Confirmation Statement

I submitted my claim(s) to _____ (Insurance Carrier) on _____ (Date)

For payment. After receiving no response, I contacted the carrier on _____ (Date) for confirmation.

The following information was provided for:

Recipient Name: _____
Medicaid ID#: _____
Policy Holder: _____
Policy Number: _____

Insurance Representative: _____ Telephone #: _____

_____ Insurance was cancelled on _____ (Date)

_____ Service is non-covered

_____ **Recipient not covered under this policy**

_____ MTX for Medicare non-cancer diagnosis - state pt. diagnosis: _____

_____ Medicare covered Immunosuppressant therapy limit exceeded

_____ Oral Anti-Emetics for confirmed non-cancer diagnosis – state diagnosis _____

_____ Other: _____

Thank you,

_____ (Signature) _____ (Date) _____ (Provider # or NABP#)

Pharmacist

Note: This statement must be in accordance with the provisions of Part I Policies and Procedures Chapter 200. timely Submission Section 201.3(b)

If you are using this form for Medicare exclusions, attach to claim form and send to ESI.

If you are using this form to communicate (COB) changes, FAX to ACS at 1-866-483-1044.

THIS FORM MAY BE PHOTOCOPIED

Figure 7-2. Pharmacy Coordination of Benefits (COB) Confirmation Statement

8. Electronic Claims Submission

This chapter explains the different methods to submitting and processing claims and provider support.

8.1 New Options for Claims Submissions Georgia Health Partnership

GHP uses a new computer system for claims processing, health care administration and provider support. The new GHP computer system benefits providers participating in the Medicaid and PeachCare for Kids programs in many ways:

- More ways to submit claims electronically
- Quicker payments
- Ability to adjust claims online
- Electronic support for other health care transactions; GHP provides methods for providers to submit and inquire about:
    - Member eligibility
    - Referral, prior authorization, and pre-certification
    - Presumptive eligibility
    - Provider application
    - Claims
    - Many other transactions

For more general information about GHP, visit the DCH web page at *http://www.communityhealth.state.ga.us*.

8.2 How Will I Submit Medicaid and PeachCare for Kids Claims to Georgia Health Partnership?

DCH strongly encourages electronic submission of claims and most other transactions.

You can use one or more methods to submit claims and other transactions to GHP. Every provider should be able to utilize one or more methods appropriate for their size and computer capabilities.

NOTE:
Any hardware changes or software upgrades or purchases are at the expense of the provider.

8.2.1 Georgia Health Partnership Web Portal

You can submit claims and other transactions using the GHP Web Portal specifically developed for Georgia Medicaid and PeachCare for Kids. Transactions can be keyed individually or submitted in batches from your computer system. Batches must be in 837P, 837D, or proprietary format. (Batches submitted via proprietary formats are only accepted through October 16, 2003.)

Online editing and claims adjustment can be done in real time via the web portal *(www.ghp.georgia.gov*). Inquiries can also be made from the web portal. Web functions are available for all claims, regardless of the method used to submit them. For additional information on claims submission via the web portal, contact the CIC at (404) 298-1228 (Metro Atlanta) or (800) 766-4456 (toll free).

8.2.2 Dial-up Using WINASAP2000

WINASAP2000 software is available to providers from GHP (free of charge). This software is similar to the Electronic Media Claim (EMC) field software currently used by some providers to submit claims. No Internet access is needed. Providers can use their personal computers (PCs) with a modem and an ordinary phone line to access the new system. WINASAP2000 can be downloaded from *www.acs-gcro.com.* You may also obtain a copy on CD-ROM by calling (800) 987-6715.

8.2.3 Dial-Up Using Other Software

You can use other software not supplied by GHP, via ordinary phone lines, to submit batches of claims as long as they are in the acceptable formats. There are many possibilities, ranging from inexpensive electronic data capture and submission software to complex hospital and practice management computer systems. The key difference between this option and WINASAP2000 is that WINASAP2000 is a self-contained software package, while other dial-up methods may require some modifications to your existing system. The specifications for these modifications are available to your billing support staff, billing agents or Information Technology (IT) department. These specifications are available in the form of documents called "Companion Guides." The Companion Guides can be obtained by visiting *www.acs-gcro.com* or by calling (800) 987-6715.

8.2.4 Clearinghouse

A clearinghouse is a company that accepts claims from a provider and routes them to fiscal agents and other payers. The clearinghouse can also take responsibility for translating claims into formats that payers require. If you currently submit Medicaid and PeachCare for Kids claims via a clearinghouse, you can continue to do so with the new system as long as the clearinghouse makes the necessary arrangements and modifications, based on the specifications available.

8.2.5 Billing Agent

A billing agent is a company that acts as a third party to providers, actually billing or entering the electronic claims on behalf of the providers. As with clearinghouses, providers are able to continue to use their current billing agent once the billing agent makes the required arrangements and changes to submit to the new system.

Lists of certified vendors, billing agents and clearinghouses are available from ACS EDI Gateway Services, which can be contacted at *www.acs-gcro.com* or by calling (800) 987-6715.

8.2.6 Tape Cartridge, Host-to-Host

Some large hospitals and other facilities currently submit claims to GHP on tape cartridges or "host-to-host" through telecommunication lines. These options continue to be available with GHP and are expanded to include additional types of transactions. These claim submissions must be in the required format.

Table 8-1. Benefits of Electronic Submission

Benefits of electronic submission include:	
• More streamlined business process • Faster transfer of data • Security of data with user passwords	• Far fewer errors • Saves unnecessary recapture of data • Less time wasted on exception handling

8.2.7 Receiving Data Electronically from the Georgia Health Partnership

Providers have several options for receiving transactions and other data back from GHP. Following are the methods to receive transactions and other data:

- For transactions keyed individually into the GHP Internet Web Portal, feedback is provided immediately on the provider's computer screen.
- For transactions submitted in batches, providers may obtain feedback via one of two methods.
    - Information may be downloaded from the Internet web site.
    - For providers that do not use the Internet to submit and receive data from GHP, information may be downloaded from a bulletin board system (BBS) that can be accessed via a dial-up computer connection.

8.3 Choosing an Electronic Data Interchange Method

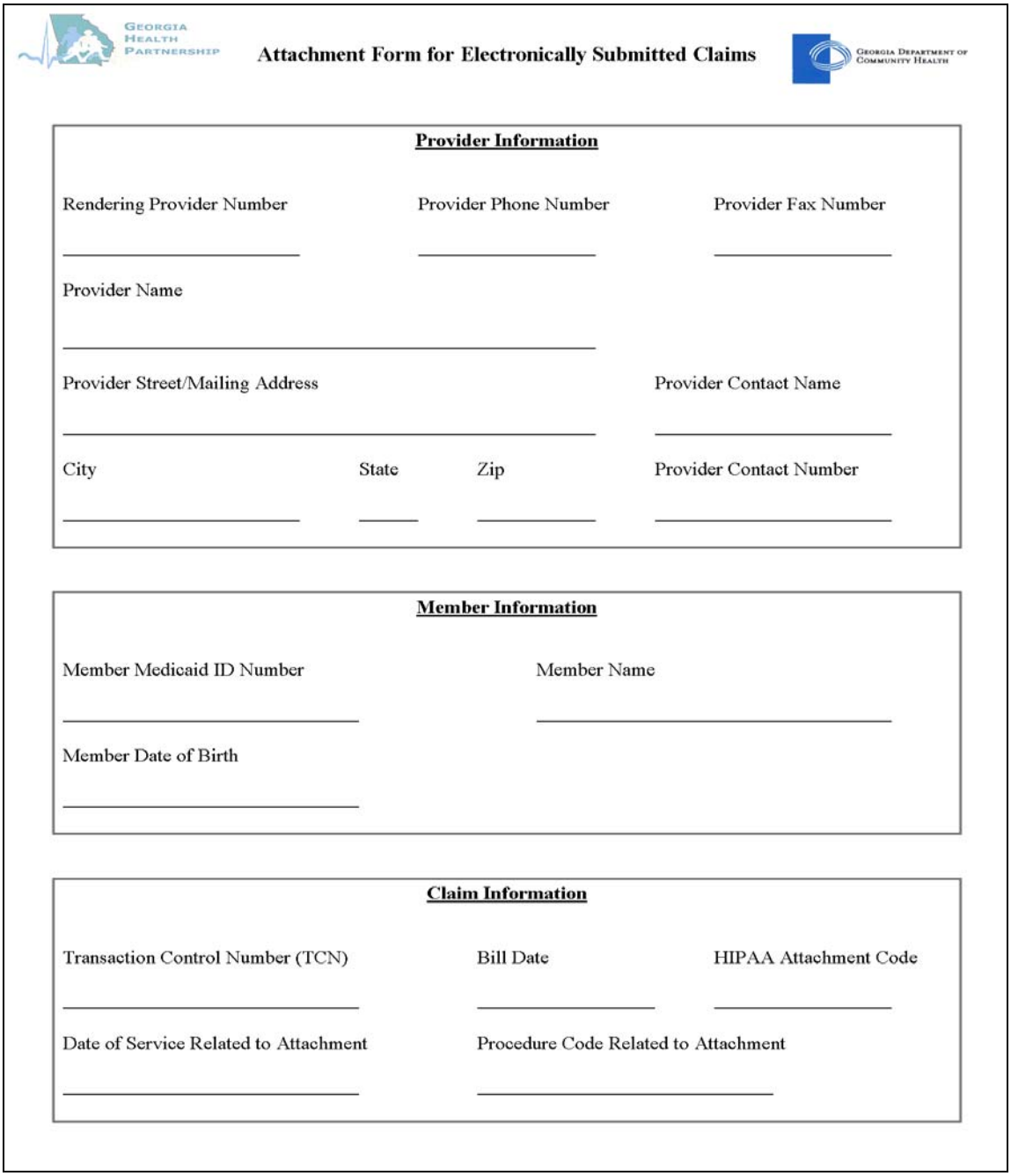
The following chart helps you understand and determine the best electronic claim submission solution(s) for your practice or facility.

Table 8-2. Electronic Data Interchange Options

Electronic Data Interchange Options			
Method	**Requirements**	**Transactions Supported**	**Feedback Methods**
Internet Web Portal	• Computer with browser and Internet access. The portal supports Internet Explorer 5.0 or higher and Netscape 4.7.2 or higher. • Transactions may be keyed individually (also called interactive entry) OR • Transactions may be submitted in batches. For this option, your vendor, clearinghouse, or billing agent must use HIPAA standards	• Claim submission and inquiry • Eligibility inquiry and response • Prior authorization request and response • Provider application • Member presumptive eligibility • Batch and individual claims submission • Editing, adjusting, and voiding of claims	• Real-time feedback via web for individual entry • Web portal (preferred) or bulletin board system (BBS) for batch submissions
Dial-up WINASAP 2000	• Computer with dial-up capability • Windows 95 (or higher) operating system • Pentium or equivalent processor • CD-ROM drive • 50 megabytes of free disk space • WINASAP2000 software available free from GHP • Hayes-compatible 9600 baud asynchronous modem • Telephone connectivity	• Claim submission (key claims into WINASAP, then dial up GHP to submit)	• Immediate Confirmation of Receipt • Remittance advice via web portal or BBS
Other Dial-up Software	• Hardware requirements are determined by the software vendor • Computer with dial-up capability • Ability to format files as HIPAA or other supported standards	• Claim submission and inquiry • Eligibility inquiry and response • Prior authorization request and response	• Web portal (preferred) • BBS
Clearing-house or Billing Agent	• Ability to format files as HIPAA or other supported standards	• Claim submission and inquiry • Eligibility inquiry and response • Prior authorization request and response	• Web portal (preferred) • BBS
Tape Cartridge, Host-to-Host	• Ability to format files as HIPAA or other supported standards	• Claim submission and inquiry • Eligibility inquiry and response • Prior authorization request and response	• Web portal (preferred) • BBS

8.4 Submitting Page Attachments for Electronically Submitted Claims

When electronically billing claims that require the submission of a paper attachment, providers should use the following form.



Georgia Health Partnership

Attachment Form for Electronically Submitted Claims

Georgia Department of Community Health

Provider Information

Rendering Provider Number _____

Provider Phone Number _____

Provider Fax Number _____

Provider Name _____

Provider Street/Mailing Address _____

Provider Contact Name _____

City _____ State _____ Zip _____

Provider Contact Number _____

Member Information

Member Medicaid ID Number _____

Member Name _____

Member Date of Birth _____

Claim Information

Transaction Control Number (TCN) _____

Bill Date _____

HIPAA Attachment Code _____

Date of Service Related to Attachment _____

Procedure Code Related to Attachment _____

Figure 8-1. Attachment Form for Electronically Submitted Claims

9. Remittance Advice

This chapter describes the contents of a Remittance Advice (RA). It includes generic advice statements with descriptions that identify the meaning of the lines on the remittance advice. This chapter also contains valuable "how-to" information for getting the most benefits from the information displayed on a remittance advice

9.1 Methods for Obtaining a Remittance Advice

Each provider is asked to select a method of delivery as part of Provider Enrollment, either paper or electronically through the Message Center from My Workspace. These methods include:

- X12N 835 electronic transaction
- Print image (via the web portal)
- Paper (via mail)

You can change your selection at any time by updating your account online.

9.2 Remittance Advice Contents

All claims are processed to create a weekly statement to providers. All pages are numbered. This statement, a RA statement, contains these sections:

- Header Page
- Financial Summary Sheet
- Payment Sheets
- Carrier Data Page

9.2.1 Remittance Advice Header Page

The following figure represents the first page of the RA. It is called the *Header Page*. It contains your address and the address of the GHP. If your address changes or you received the wrong remittance advice, contact the Customer Interaction Center (CIC) by dialing:

- (404) 298-1228 (Metro Atlanta) or
- (800) 766-4456 (toll free).

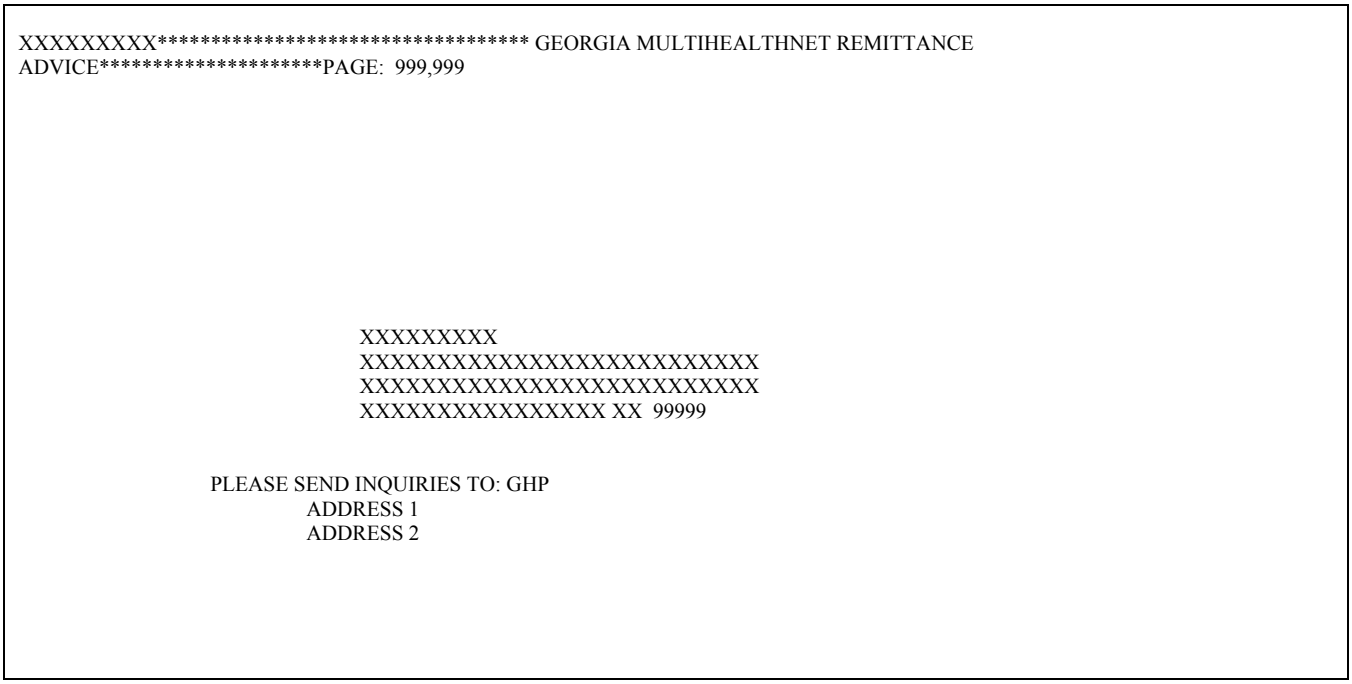


Figure 9-1. Remittance Advice Header Page

9.2.2 Remittance Advice Second Page

The second page of the RA displays the provider's name, address, and provider number. Contact the CIC if any of this information is incorrect. It also displays information about this specific RA, including the number assigned for the payment cycle. It displays the remittance sequence number, based on the total number of remittances issued to the provider. This number is sequential, so you can use it to tell if a remittance is missing.

The provider name, address, and ID number appear in the top left corner of the page. The date, payment cycle number, sequence number, and page number appear in the top right corner of the page.

Banner messages appear as text boxes in the center of the page.

```
XXXXXXXXXXXXXXXXXXXXXXXXXXX        GEORGIA MULTIHEALTHNET SYSTEM                 DATE:  99/99/99
XXXXXXXXXXXXXXXXXXXXXXXXXXX       DEPARTMENT OF COMMUNITY HEALTH           REMITTANCE:  99999999
XXXXXXXXXXXXXXXX XX  99999             REMITTANCE ADVICE                    REMIT SEQ: 9999

                              PAGE:   99999999
PROVIDER NO: 999999999-XXX                                        RPT PAGE:  999999999

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX




XXXXXXXXXXXXXXXXXXXXXXXXXXX        GEORGIA MULTIHEALTHNET SYSTEM                 DATE:  99/99/99
```

Figure 9-2. Second Page

9.3 Remittance Advice of Professional Services

The following figure depicts the Member Name Line Information on the RA. The Member Name line appears just below the provider information.

9.3.1 Member Name Line

```
XXXXXXXXXXXXXXXXXXXXXXXXX                    GEORGIA MULTIHEALTHNET SYSTEM
DATE:  99/99/99
 XXXXXXXXXXXXXXXXXXXXXXXXX                  DEPARTMENT OF COMMUNITY HEALTH
REMITTANCE:  99999999
 XXXXXXXXXXXXXXXXXXXXXXXXX                   REMITTANCE ADVICE
REMIT SEQ:  99999999
 XXXXXXXXXXXXXX  XX  99999
PAGE:  99999999
 PROVIDER NO: 999999999-XXX                                                                                                RPT PAGE:
999999999
 CLAIM TYPE P - PHYSICIAN    ADJUDICATED
 ------------------------------------------------------------------------------------------------------------------------------------------------------------
-------------------------
 RECIPIENT ID   RECIPIENT NAME       MED REC NUMBER              TCN              SVC PROV
 LN  SERVICE DATES          PROC     PM   PM ALWD-UNITS   BILLED   COPAY PD   ALWD+TAX    TPL       PAYMENT     EOB
STATUS
 ------------------------------------------------------------------------------------------------------------------------------------------------------------
-------------------------

 999999999999 XXXXXXX,XXXXXXXXX X 999999999999999   99999999999999999   XXXXXXXXX
 01  99/99/99 99/99/99          99999       XX   XX   99999.99-   999999.99-   999.99-    999999.99-     999999.99-  999999.99-   9999 9999
DENY
 EOB CODES: 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 02  99/99/99 99/99/99          99999       XX   XX   99999.99-   999999.99-   999.99-    999999.99-     999999.99-  999999.99-
PAID
 DUPLIC TCN: 99999999999999999 DATED: 99/99/99
                                                  CLAIM TOTAL:  999999.99-   999.99-    999999.99-     999999.99-  999999.99-

 999999999999 XXXXXXX,XXXXXXXXX X 999999999999999   99999999999999999   XXXXXXXXX                                          9999
9999
 EOB CODES: 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 01  99/99/99 99/99/99          99999       XX   XX   99999.99-   999999.99-   999.99-    999999.99-     999999.99-  999999.99-
DENY
                                                  CLAIM TOTAL:  999999.99-   999.99-    999999.99-     999999.99-  999999.99-
 FORMER TCN: 99999999999999999 DATED: 99/99/99


 ADJUDICATED  TOTALS:  9999 CLAIM LINES                  9999999.99-  9999.99-    9999999.99-   9999999.99- 9999999.99-
```

Figure 9-3. Member Name Line Information

A Member Name line appears for each claim on the RA and includes one of these two sets of information:

- Member ID number
- Member name
- Patient control number

or

- Patient record number
- Transaction Control Number (TCN)
- Claim payment remark codes

9.3.2 Claim Line Information

The following figure depicts the Claim Line Information on the RA. The Claim Line Information line appears immediately below the Member Name line.

```
 XXXXXXXXXXXXXXXXXXXXXXXXXXX                    GEORGIA MULTIHEALTHNET SYSTEM
DATE:   99/99/99
 XXXXXXXXXXXXXXXXXXXXXXXXXXX                 DEPARTMENT OF COMMUNITY HEALTH
REMITTANCE:   99999999
 XXXXXXXXXXXXXXXXXXXXXXXXXXX                   REMITTANCE ADVICE
REMIT SEQ:   99999999
 XXXXXXXXXXXXXXX  XX  99999
PAGE:   99999999
 PROVIDER NO: 999999999-XXX                                                                  RPT PAGE:
999999999
 CLAIM TYPE P - PHYSICIAN
    ADJUDICATED
 ---------------------------------------------------------------------------------------------------------------
-------------------------
 RECIPIENT ID   RECIPIENT NAME      MED REC NUMBER           TCN            SVC PROV
 LN  SERVICE DATES            PROC     PM    PM ALWD-UNITS   BILLED   COPAY PD    ALWD+TAX     TPL       PAYMENT     EOB
STATUS
 ---------------------------------------------------------------------------------------------------------------
-------------------------

 999999999999 XXXXXXX,XXXXXXXXX X 999999999999999   99999999999999999   XXXXXXXXX
 01  99/99/99 99/99/99          99999       XX   XX   99999.99-    999999.99-   999.99-     999999.99-      999999.99-  999999.99-   9999 9999
DENY
 EOB CODES: 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 02  99/99/99 99/99/99          99999       XX    XX   99999.99-    999999.99-   999.99-     999999.99-      999999.99-  999999.99-
PAID
 DUPLIC TCN: 99999999999999999 DATED: 99/99/99
                                              CLAIM TOTAL:  999999.99-   999.99-     999999.99-      999999.99-  999999.99-

 99999999999999 XXXXXXX,XXXXXXXXXXX X 999999999999999   99999999999999999   XXXXXXXXX                        9999
9999
 EOB CODES: 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 01  99/99/99 99/99/99          99999       XX    XX   99999.99-    999999.99-   999.99-      999999.99-     999999.99-  999999.99-
DENY
                                              CLAIM TOTAL:  999999.99-   999.99-      999999.99-     999999.99-  999999.99-
 FORMER TCN: 99999999999999999 DATED: 99/99/99


 ADJUDICATED  TOTALS:  9999 CLAIM LINES                 9999999.99-  9999.99-    9999999.99-   9999999.99- 9999999.99-
```

Figure 9-4. Claim Line Information

Each claim contains several lines of information, and the lines in each claim are numbered. The Claim Line Information line includes these items:

- Line number
- Tooth (only if you are a dental provider)
- Procedure code
- Procedure code modifier
- Allowed units
- Amount billed

- Dates of service from/to
- Copay paid
- Amount allowed plus tax
- Claim payment remark codes
- Status

9.4 Claim Total

The following figure depicts the Claim Total on the RA. Each individual claim is totaled on the remittance advice.

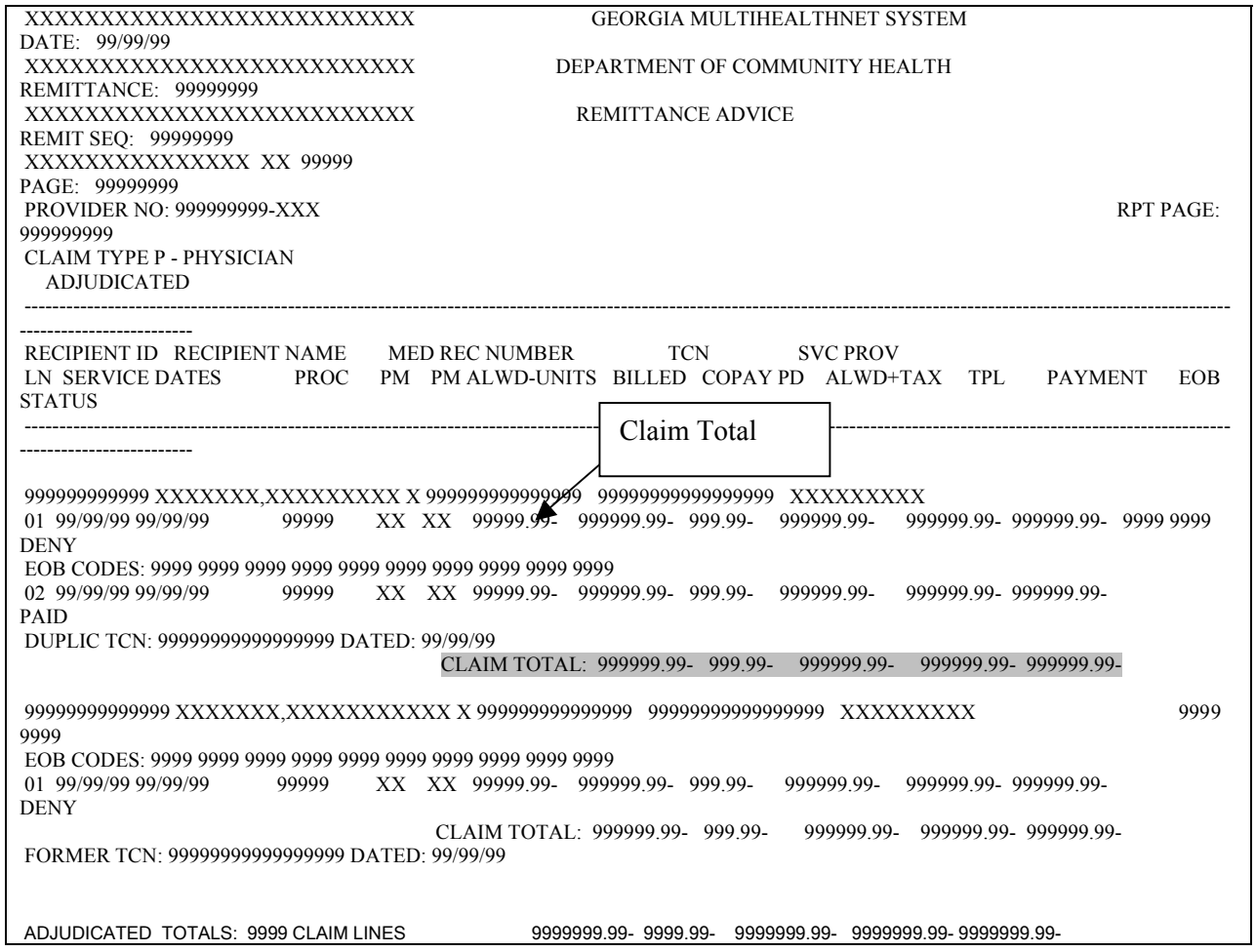


Figure 9-5. Claim Total

A Claim Total line appears for each individual claim and includes these items:

- Amount billed
- Copay paid
- Amount allowed plus tax
- COB

9.5 Section Totals

The following figure depicts the Section Total on the RA. Claims are separated by status: adjudicated, adjusted, denied, or voided. The remittance advice includes subtotals for each claim status.

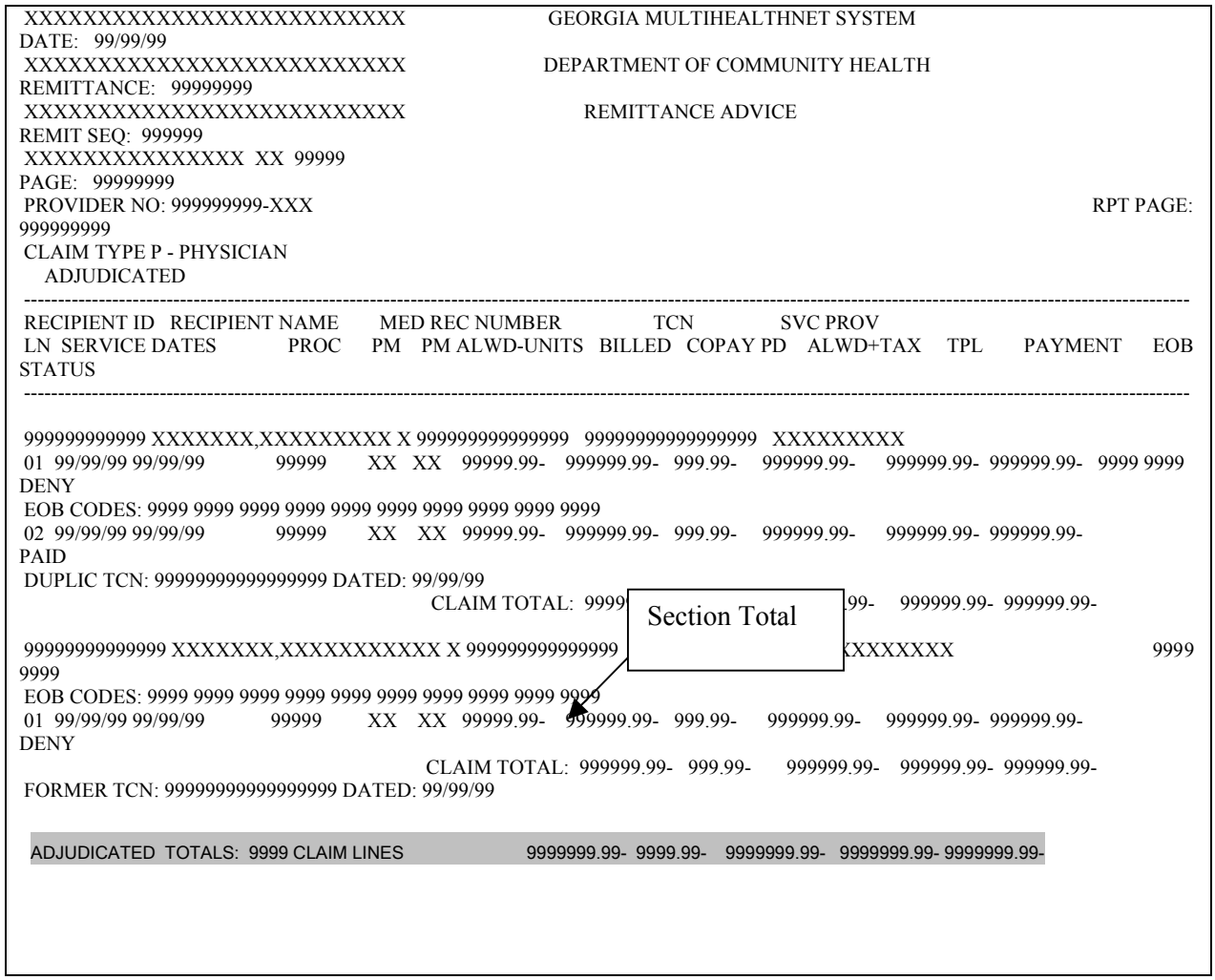


Figure 9-6. Section Totals

The Section Total line may include the adjudicated section, adjustment totals, or the voided total. This information includes these totals:

- Total number in current section
- Amount billed
- Copay paid
- Amount allowed plus tax
- COB
- Payment amount

9.6 Institutional Remittance Advice

The Member Name line for Institutional Remittance Advices is the same as the one on the Remittance Advice for Professional Services. Several types of claims are included in this claim category.

9.6.1 Diagnosis Related Group

The Diagnosis Related Group (DRG) type of institutional claim reflects a difference in payment methods.

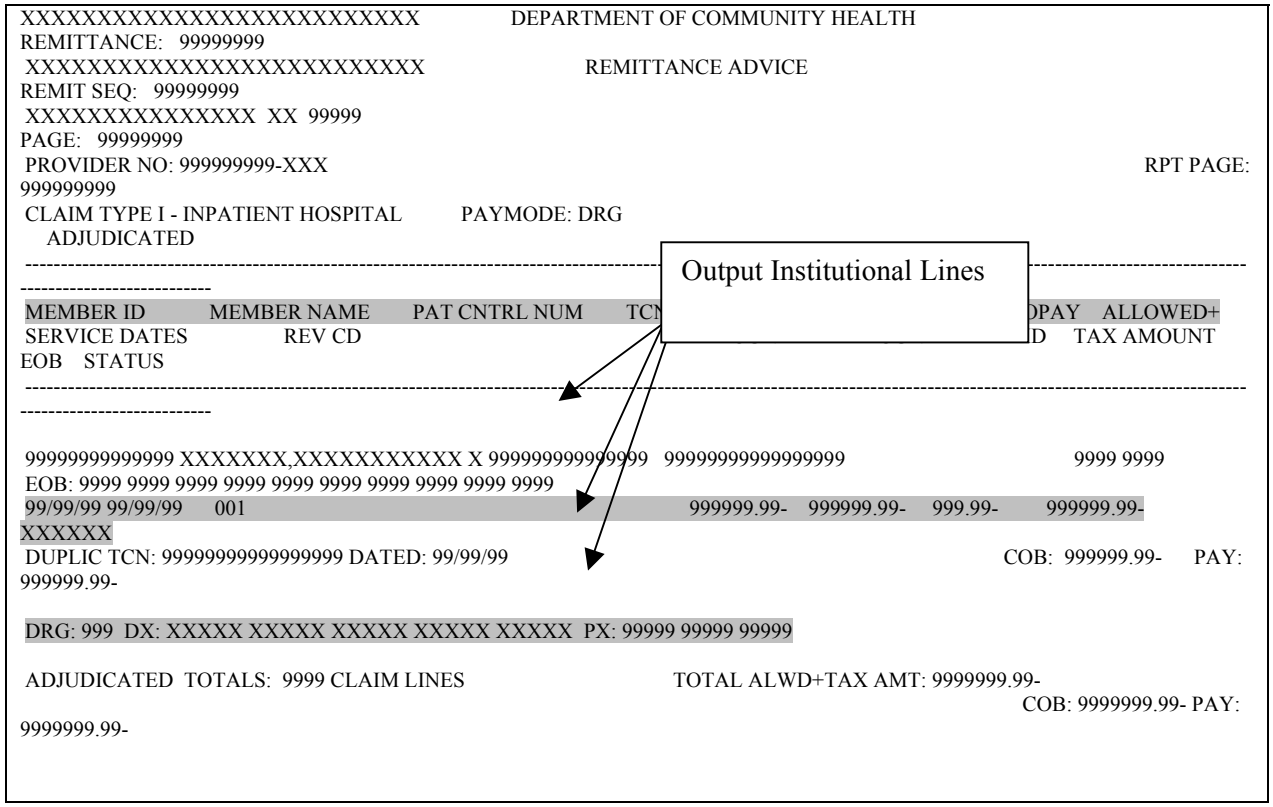


Figure 9-7. Diagnosis Related Group

The DRG Institutional line includes these items:

- DRG (DRG Code)
- Diagnosis code
- Hospital surgical procedure code

9.6.2 Outpatient Institutional Claim

```
 XXXXXXXXXXXXXXXXXXXXXXXXXXX                    GEORGIA MULTIHEALTHNET SYSTEM
DATE:   99/99/99
 XXXXXXXXXXXXXXXXXXXXXXXXXXX                   DEPARTMENT OF COMMUNITY HEALTH
REMITTANCE:   99999999
 XXXXXXXXXXXXXXXXXXXXXXXXXXX                             REMITTANCE ADVICE                                  REMIT
SEQ:   99999999
 XXXXXXXXXXXXXXX  XX  99999
PAGE:   99999999
 PROVIDER NO: 999999999-XXX                                                                          RPT PAGE:
999999999
 CLAIM TYPE O - OUTPATIENT HOSPITAL
    ADJUDICATED
 -----------------------------------------------------------------------------------------------------------------
 MEMBER ID       MEMBER NAME       PAT CNTRL NUM       TCN     BILLED    NONCOVERED     COPAY    ALLOWED+
 SERVICE DATES      REV/HCPC                 UNITS                       AMOUNT      AMOUNT           PAID   TAX AMOUNT
EOB       STATUS
 -----------------------------------------------------------------------------------------------------------------

 99999999999999 XXXXXXXX,XXXXXXXXXX X 99999999999999   99999999999999999                                   9999
9999
 EOB: 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 DUPLIC TCN: 99999999999999999 DATED: 99/99/99
 99/99/99 99/99/99   999/99999           999-                        999999.99-     999999.99-       999.99-       999999.99-       9999 9999
XXXXXX
 99/99/99 99/99/99   999/99999           999-                        999999.99-     999999.99-       999.99-       999999.99-       9999 9999
XXXXXX
 EOB: 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 99/99/99 99/99/99   999/99999           999-                        999999.99-   999999.99-       999.99-      999999.99-       9999 9999
XXXXXX
 99/99/99 99/99/99   001                                                       999999.99-   999999.99-        999.99-     999999.99-
                                                                                                 COB:  999999.99-          PAY:
999999.99-

 ADJUDICATED  TOTALS:  9999 CLAIM LINES                     TOTAL ALWD+TAX AMT: 9999999.99-
                                                                                                  COB: 9999999.99-          PAY:
9999999.99-
```

Figure 9-8. Outpatient Institutional Claim, Claim Totals

The Outpatient Institutional Claim may contain multiple lines. Each line contains the following:

- Dates of service from/to
- Revenue code/HCPCS code
- Units
- Billed amount
- Noncovered amount
- Copay paid
- Allowed plus (+) tax amount
- Claim payment remark codes
- Status

9.6.3 Claim Total

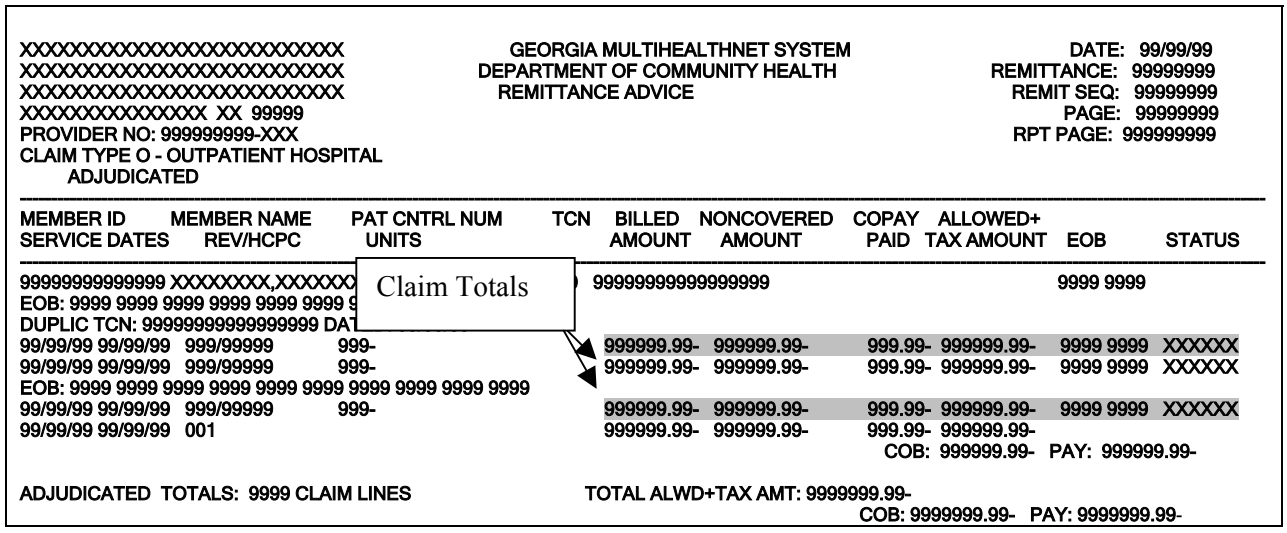


Figure 9-9. Claim Total

Each outpatient institutional claim is totaled. The second line in the Claim Total includes the COB and payment amounts. The information in the Claim Total line includes these items:

- Billed amount
- Noncovered amount
- Copay paid
- Allowed plus tax
- COB
- Payment

9.6.4 Adjustments and Voids

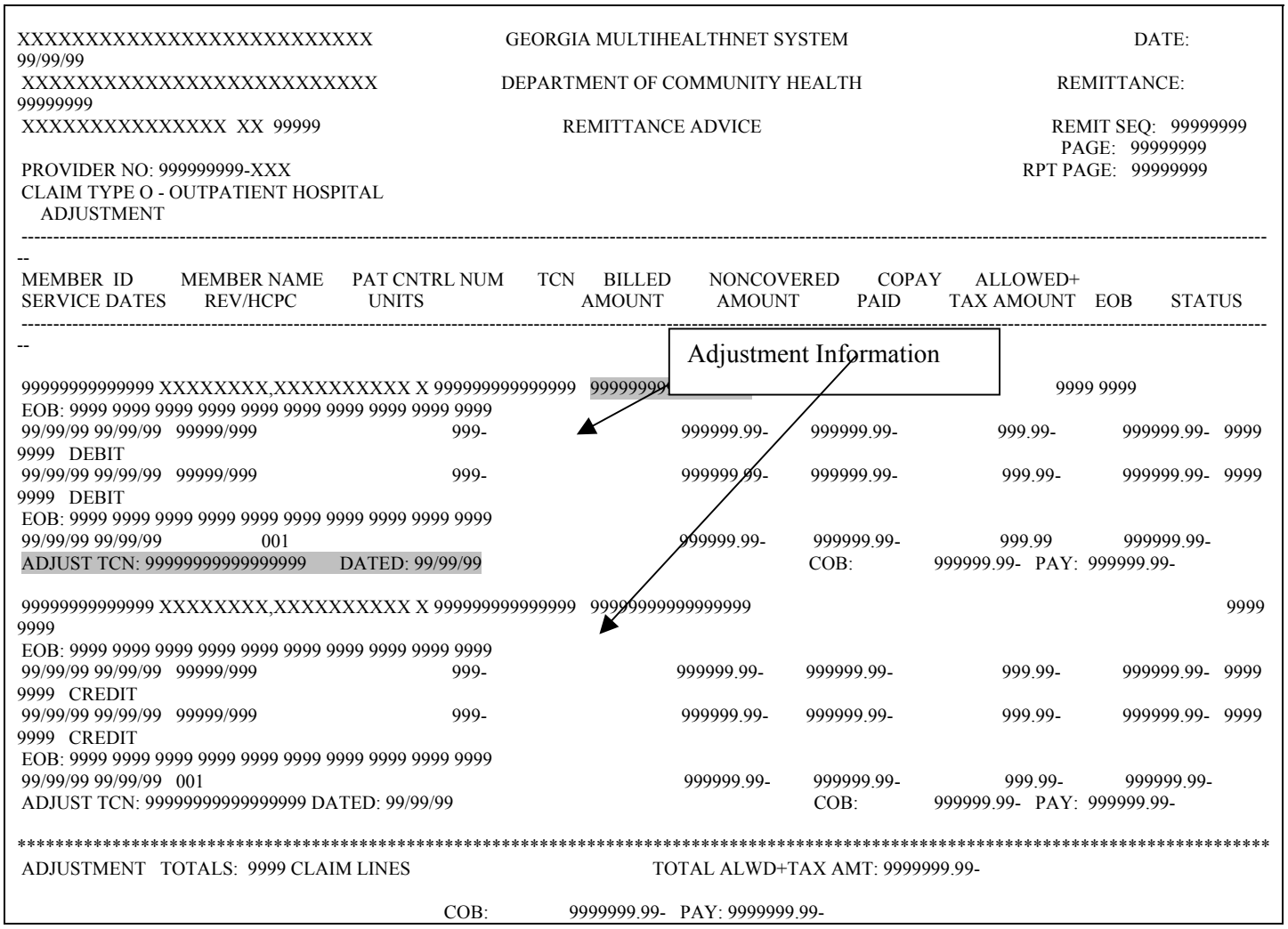


Figure 9-10. Adjustments and Voids

The adjusted claim was designed to help you reconcile reports. It contains the same lines as other claims of its type. However, it also contains these two additional pieces of information:

- Former TCN (claim number)
- Adjusted TCN (claim number)

Any claims that have been voided also appear on the remittance advice, along with the date of the void.

No other claim numbers are associated with the voided claim. If you resubmit the claim information from the voided claim, the resubmitted claim is assigned a new TCN and is not linked to the voided claim.

9.6.5 Voided Claims

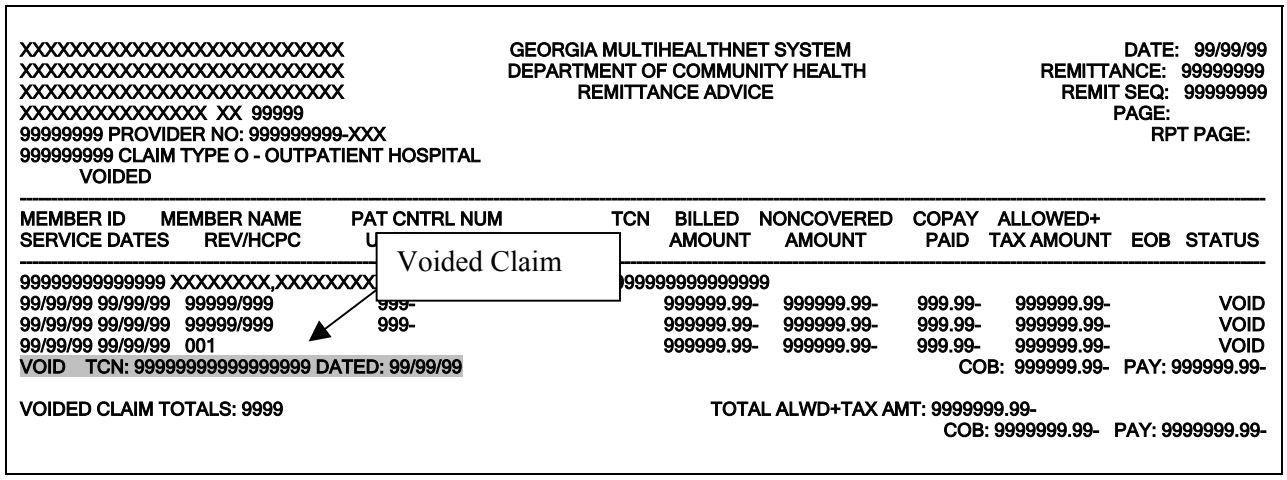


Figure 9-11. Voided Claims

Any claims that have been voided will also appear on remittance advice, along with the TCN and date of the void.

No other claim numbers will be associated with the voided claim. If you resubmit the claim information from the voided claim, it will be assigned a new TCN and will not be linked to the voided claim.

9.6.6 Coordination of Benefits Information

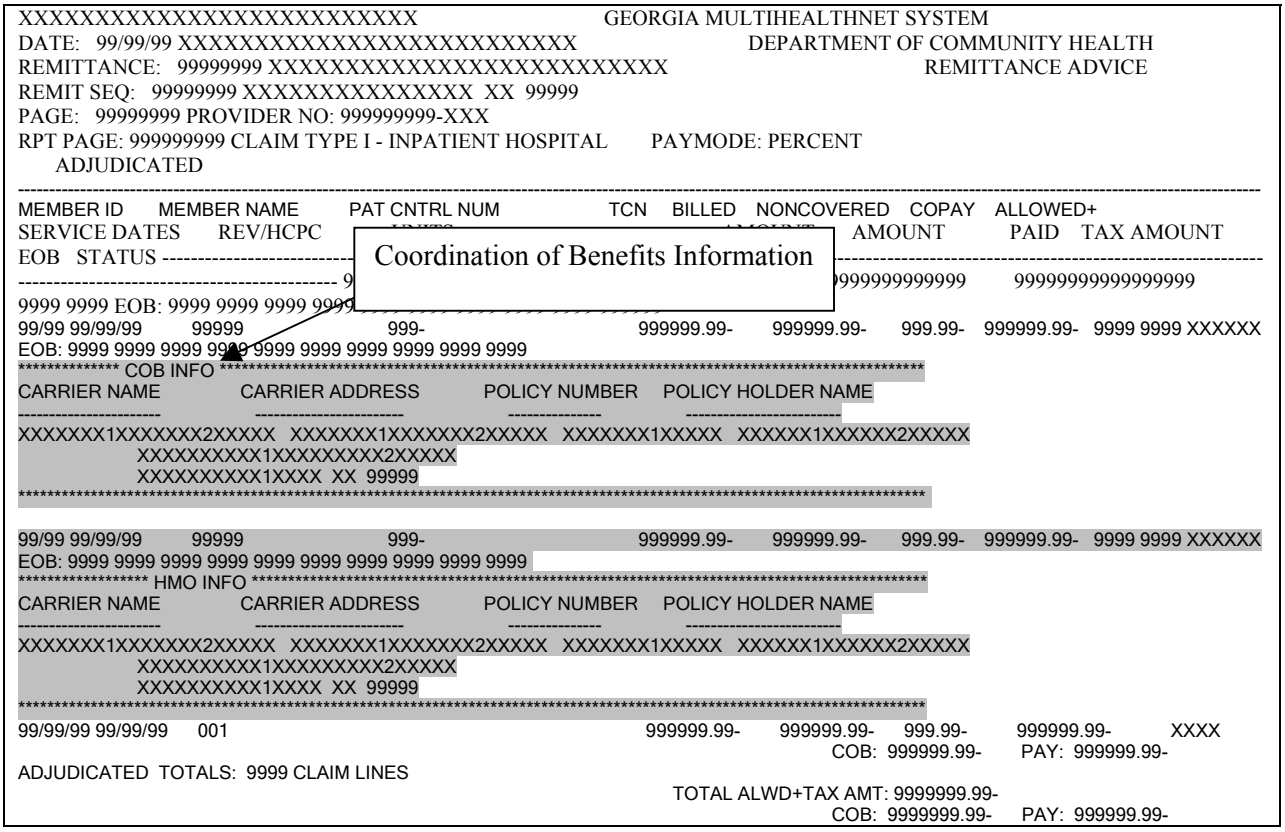


Figure 9-12. COB Information

When the claim is denied at the header level, this information appears in the COB info box:

- Carrier name/address
- Policy number
- Policyholder name

This information appears when the claim is denied at the line item level:

- Service dates from/to
- Billed Amount
- Noncovered amount
- Copay paid
- Allowed plus (+) tax amount
- Status
- COB amount received
- Final payment amount

10. Financial Summary Page Adjustments

This chapter includes an explanation of adjustments, a copy of the Adjustment Request form, and instructions for completing the Adjustment Request form.

10.1 Adjusting a Paid Claim

If you receive an inaccurate claim payment or receive a payment from a third party after Medicaid has paid, then you must submit an Adjustment Request form or adjust on the web portal to correct the claim payment. If you submit on paper, the Adjustment Request form must be submitted for each claim to be adjusted. The adjustment request must be submitted with a copy of the Remittance Advice that corresponds to the claim payment.

Mail all Adjustment Request forms to:

GHP
Attn: Adjustment Request
P.O. Box 5000
McRae, GA 31055

10.2 Refund Adjustments Due to Error

You should use a personal check to refund a Medicaid overpayment. If the overpayment is due to an error on the claim, then you can include a completed Adjustment Request form with the overpayment refund. The completed form should include, within the narrative, the correct data to be applied to the claim.

10.3 Refund Adjustments Due to Third-Party Overpayment

You must refund payments that were received from a third party after Medicaid had already paid the claim. Adjustments can also be done on the web, creating a receivable against future payments. A refund is due within 30 days after the provider received the overpayment. Along with the refund check, the provider should also send these three items:

- A completed Adjustment Request form
- A copy of the Medicaid Remittance Advice that corresponds to the claim payment
- A copy of the Remittance Advice received from the third party

All refund checks and accompanying documentation must be mailed to the following address. Providers and hospitals use separate addresses.

Table 10-1. Addresses for all Refund Checks and Accompanying Documentation

Provider	Hospital
Bank of America Lock Box 277941 Atlanta, GA 30384	Bank of America Lock Box 406867 Atlanta, GA 30384

10.4 Filing Limitation

Adjustment requests must be received within three months following the month of Medicaid payment. The payment date is reflected in the date located in the top right hand corner of the Remittance Advice page.

Only paid claims can be adjusted. When an adjustment is performed, the original claim is voided resulting in the recovery if the entire paid amount. A new claim, the adjustment claim, is then created in the system, which incorporates the necessary requested changes and repays the provider for the services rendered. A paid claim can only be adjusted once due to this void and recovery process; however, an adjustment can be requested to the adjustment claim if additional changes are needed.

10.5 Adjustment of Inaccurate Medicare/Medicaid Payments

To appeal the amount paid for services to Medicaid/Medicare members, notify the appropriate Medicare Fiscal Intermediary of your appeal. (Any additional payment is through both Medicare and Medicaid.) If the payments are made to an incorrect provider or are above the amount due, return the erroneous checks or issue refunds to Medicare and to Medicaid for their respective shares. Any erroneous Medicaid payments or refunds due to DCH must be forwarded to the following address:

Table 10-2. Addresses for all Erroneous Medicaid Payments or Refunds

Provider	Hospital
Bank of America Lock Box 277941 Atlanta, GA 30384	Bank of America Lock Box 406867 Atlanta, GA 30384

10.6 Adjustment Request Form

Please mail to:

GHP
P.O. Box 5000
McRae, GA 31055

10.6.1 Adjustment Request Form (DMA-501)

Adjustment Requests must be received within three months from the month of Medicaid payment.

1. Transaction Control Number (TCN) / Internal Control Number (ICN) of the **paid** claim to be adjusted as shown on the Remittance Advice	3. Provider Name/Address
Member Medicaid Information 2. Medicaid Number Member Name (Last, First, Initial)	Provider Number Phone Number: ( ) _____ - _____ Provider Contact Person:

4. Reason for adjustment (check one box)

A. ☐ Apply COB (indicate amount in Block #5D)
B. ☐ Change information as indicated in Block 5 below
C. ☐ Void claim
D. ☐ Medicare adjustment (attach all EOMB's that apply to this adjustment)

5. Please list the information to be corrected in Blocks 5A-5D. If the information to be corrected does not have a line number enter zero in the line number field. COB applied should always be line #0.

5A Line to be Corrected	5B Information to be Changed	5C From (Current) Information	5D To (Corrected) Information

6. Explanation for Adjustment

7. FOR DCH USE ONLY

CCN _____ FS Line Amount $ _____

Provider Signature _____ Date _____

Figure 10-1. Adjustment Request Form

10.7 Completion of the Adjustment Request Form

Please complete the Adjustment Request Form (DMA-501) as completely and accurately as possible. Incomplete or inaccurate information can delay the adjustment process. **Don't forget:** if you submit on paper, attach a copy of the associated Remittance Advice page before mailing your request.

Table 10-3. Completion of the Adjustment Request Form

Item	Item Description	What You Must Do
1	Transaction Control Number (TCN) / Internal Control Number (ICN)	Enter the 17-digit Transaction Control Number or 15-digit Internal Control Number assigned to the claim.
2	Member Medicaid Number Member Name	Enter the member number exactly as it appears on the Remittance Advice for the TCN or ICN. Enter the name of the member exactly as it appears on the Remittance Advice for the TCN or ICN.
3	Provider Name / Address Provider Number Phone Number Provider Contact Person	Enter the provider's name and address. Enter the identifying number assigned by the Provider Enrollment Unit. Enter the telephone number, including area code. Enter the name of a person who can be contacted regarding the adjustment, if necessary.
4	Reason for Adjustment	Mark an 'X' in the box that best explains the adjustment.
5	Please list the information to be corrected in Blocks 5A-5D. If the information to be corrected does not have a line number, enter zero in the line number field. COB applied should always be line #0.	Complete 5A-5D as needed.
5A	Line to be Corrected	Enter the line from the Remittance Advice in Block 5A.
5B	Information to be Changed	Write the item to be changed in Block 5B, such as procedure code, quantity.
5C	From (Current) Information	Enter the incorrect information in Block 5C as it appears on the Remittance Advice, such as procedure, quantity.
5D	To (Corrected) Information	Write the corrected information for that item in Block 5D.
6	Explanation for Adjustment	Use this area to list any additional information that may be needed to process the adjustment request. Always attach a copy of the RA page showing the paid claim information to clarify your request.
7	For DCH Use Only Provider Signature and Date	Leave blank. The provider must sign and enter the date.

10.8 Return to Provider Adjustment Letter

Examples of missing information required for processing adjustment/voids include:

- Missing signatures
- Print or ink too light to microfilm
- Incorrect/incomplete attachments
- Incorrect claim type
- Provider number incomplete or missing

The adjustment/voids are returned when possible. To process for payment, the adjustment/voids must be resubmitted with the corrected or additional information. A Return to Provider (RTP) Adjustment letter attached to the adjustment/voids lists the reason for the returned information.

An example of the Return to Provider Adjustment Letter is shown on the following page. (See Figure 10-2)

_____ Date: _____

_____

Dear Provider:

Your Adjustment Request form has been reviewed and is being returned for the following reason(s):

_____ The claim(s) you are attempting to adjust is/are over the timely filing limit. Claim Adjustments must be submitted to Georgia Medicaid within 3 months of the date of payment/denial. Therefore, your adjustment request cannot be processed.

_____ An adjustment was previously completed for this TCN (claim reference number). Please review your Medicaid Remittance Advice (RA) dated for this adjustment transaction.

_____ Only one TCN (claim reference number) can be adjusted for each form submitted.

_____ Missing, Invalid, or Incomplete -

_____ Rendering Provider ID

_____ Member ID

_____ Original TCN/ICN

_____ This claim is a previously voided claim. Your void request cannot be processed.

_____ Adjustment Requests must be submitted with the rendering provider number.

_____ Provider signature is missing.

Other:

_____

_____

_____

_____

Contact the GHP Customer Interaction Center if you have any questions:

P.O Box 5000
McRae, GA 31055
Telephone: (404) 298-1228
Toll Free: 1-800-766-4456

Sincerely, GHP Claim Adjustments Staff

Specialist ID: _____

Figure 10-2. Return to Provider Adjustment Letter

11. Appendix A: Categories of Service Numbers

Following are numbers associated with each Category of Service (COS) for each program type. The numbers are displayed in numerical order.

Table 11-1. COS Numbers

Number	Description
010/070	Inpatient or Outpatient Hospital
080	Swing-Bed Hospital
200	Home Health
230	Independent Laboratory
270	Family Planning
300	Pharmacy
320	Durable Medical Equipment
321	Pharmacy DME supplies
330	Orthotics and Prosthetics/Hearing
370	Emergency Ground Ambulance
371	Emergency Air Ambulance
380	NON-Emergency Travel
381	NET-Exceptional Transportation
410	Medicare Only Physical Therapy
420	Medicare Only Rehabilitation Therapy
430	Physicians
110, 140-180	Nursing Facility
431	Physician's Assistant
440	Medicare Only Speech Therapy
440	Community Mental Health
450	Dental
470	Vision Care
480	Nurse Midwifery
490	Oral Maxillofacial Surgery
540	Federally Qualified Health Center
541	Rural Health Center-Hospital Based
542	Rural Health Clinic
550	Podiatry
560	Medicare Only Chiropractic
570	Psychological
590	Community Care-Personal Support Service
600	Health Check (under 21)
660	Independent Care Waiver
670	Ambulatory Surgical Center/Birthing
680	Mental Retardation Waiver
690	Hospice
720	Dialysis Program – Technical
721	Dialysis Program – Professional
730	Pregnancy Related
740	Advanced Nurse Practitioner/Certified Registered Nurse Anesthetics (CRNAs)
760	Child Risk Case Management

Number	Description
760	Children At-Risk Targeted Case Management
761	Perinatal Care Management
762	Targeted Case Management for Adults AIDS
764	Child Protective Services Case Management
765	Adult Protective Services Targeted Case Management
766	Pregnant Woman Substance Abuse
767	Disease State Management Program
770	Waivered Home Care – Medical Day Care
790	Diagnostic, Screening and Preventative
800	Early Intervention Case Management
820	Medicare Only Licensed Clinical Social Worker Program
840	Children's Interventional Services
850	GBHC
851	SOURCE Case Management
900	Pre-Admission Screening Resident Review (PASRR)
910	Childbirth Education Program (non-hospital based)
930	SOURCE Program
960	Children's Interventional School Services
970	Georgia Pediatric Program-Case Management
971	GAPP In-Home Private Duty Nurse
972	CAPP Medically Fragile Daycare

12. Appendix B: Resource Tools

This appendix describes how to use the following resource tools:

- Telephone Inquiry
- Medicaid Eligibility Inquiry
- Billing Assistance
- Enrollment Changes
- Return To Provider Letter

12.1 Telephone Inquiry

You can speak with a live provider inquiry associate, Monday through Friday, 8:00 a.m. to 7:00 p.m. (except holidays). Following are the telephone numbers you can use to contact us:

- (404) 298-1228 (Metro Atlanta)
- (800) 766-4456 (toll free)

The Provider Inquiry Unit will respond to inquiries regarding:

- Billing procedures
- Claims payment/status
- Electronic claim submission
- GBHC referrals
- Member eligibility
- Member liability
- Program benefits
- Provider enrollment
- Service limitations
- Web portal functionality
- Prior authorizations and pre-certifications

12.2 Medicaid Eligibility Inquiry

Be prepared to provide the information listed below so the CIC staff can best assist you with claim problems:

- Internal Control Number (ICN) the 15-digit number found on each claim from your Remittance Advice (RA).
- Provider Number
- Date(s) of Service
- Claim Status (Paid, Denied, In Process)
- Member Name and Medicaid Number (the Medicaid ID Card if available)
- The Explanation of Benefit (EOB) or error message, if applicable to your claim

12.3 Billing Assistance

The policy and billing manuals are always the first point of reference for questions. The billing manual reviews:

- Required claim forms and necessary information
- Sample remittance advices with explanations
- Billing protocol
- Order information for forms

Billing training and EDI assistance is available to:

- Assist you with billing problems
- Install WINASAP2000 software for electronic billing
- Review billing with your staff

Call the telephone inquiry line to request billing training or assistance.

12.4 Provider Enrollment Changes

As a condition of continued Medicaid provider participation, all notifications of changes in address or enrollment must be made in writing. Enrollment changes that might affect claim reimbursement and that should be reported in writing include:

- Address/location
- Name of institution or business

- Telephone number
- License information
- Medicare provider numbers
- Federal employer identification numbers
- Social security number
- "Payee" identifying information
- Ownership information

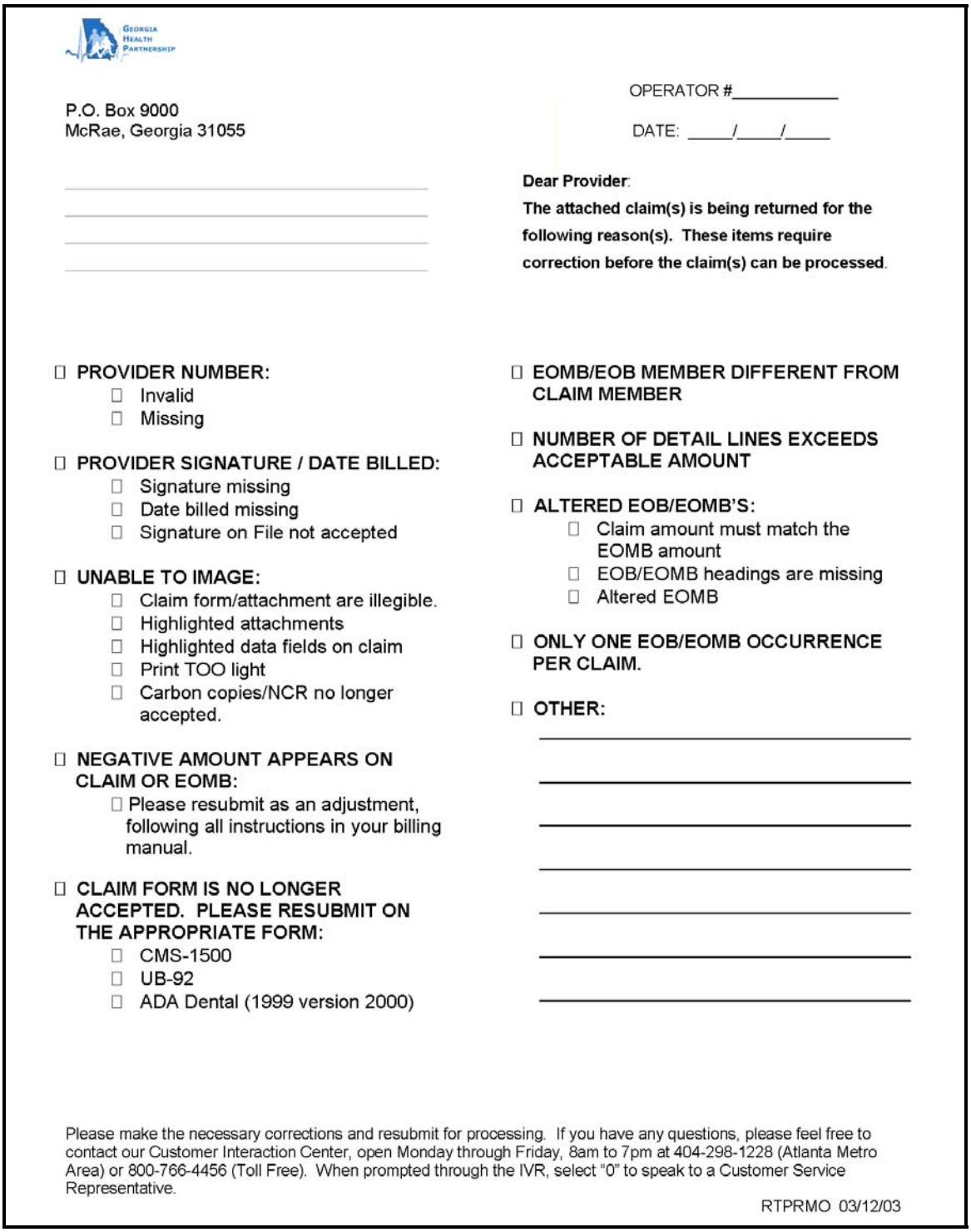
All checks for claim reimbursements that have been determined to be undeliverable by the post office are returned to the Financial Services Unit at the DCH. Financial Services personnel attempt to contact the provider by telephone to determine why the check was returned. If the check was returned due to an unreported address change, the provider is requested to forward a notification of change of address in writing to the Provider Enrollment Unit. The reimbursement check is held in the Financial Services Unit until the change information has been received. Upon receipt of the updated information, the check is mailed immediately to the new address.

12.5 Return to Provider Letter

Examples of missing information required for processing claims include:

- Missing signatures
- Print or ink too light to microfilm
- Incorrect/incomplete attachments
- Incorrect claim type
- Provider number incomplete or missing

The claims are returned when possible. To process for payment, the claim must be resubmitted with the corrected or additional information. A Return to Provider (RTP) letter attached to the claim lists the reason for the returned information.



GEORGIA HEALTH PARTNERSHIP

P.O. Box 9000
McRae, Georgia 31055

OPERATOR #_____

DATE: ____/____/____

Dear Provider:
The attached claim(s) is being returned for the following reason(s). These items require correction before the claim(s) can be processed.

☐ **PROVIDER NUMBER:**
- ☐ Invalid
- ☐ Missing

☐ **PROVIDER SIGNATURE / DATE BILLED:**
- ☐ Signature missing
- ☐ Date billed missing
- ☐ Signature on File not accepted

☐ **UNABLE TO IMAGE:**
- ☐ Claim form/attachment are illegible.
- ☐ Highlighted attachments
- ☐ Highlighted data fields on claim
- ☐ Print TOO light
- ☐ Carbon copies/NCR no longer accepted.

☐ **NEGATIVE AMOUNT APPEARS ON CLAIM OR EOMB:**
- ☐ Please resubmit as an adjustment, following all instructions in your billing manual.

☐ **CLAIM FORM IS NO LONGER ACCEPTED. PLEASE RESUBMIT ON THE APPROPRIATE FORM:**
- ☐ CMS-1500
- ☐ UB-92
- ☐ ADA Dental (1999 version 2000)

☐ **EOMB/EOB MEMBER DIFFERENT FROM CLAIM MEMBER**

☐ **NUMBER OF DETAIL LINES EXCEEDS ACCEPTABLE AMOUNT**

☐ **ALTERED EOB/EOMB'S:**
- ☐ Claim amount must match the EOMB amount
- ☐ EOB/EOMB headings are missing
- ☐ Altered EOMB

☐ **ONLY ONE EOB/EOMB OCCURRENCE PER CLAIM.**

☐ **OTHER:**

Please make the necessary corrections and resubmit for processing. If you have any questions, please feel free to contact our Customer Interaction Center, open Monday through Friday, 8am to 7pm at 404-298-1228 (Atlanta Metro Area) or 800-766-4456 (Toll Free). When prompted through the IVR, select "0" to speak to a Customer Service Representative.

RTPRMO 03/12/03

Figure 12-1. Return to Provider Letter